

**COMMISSIONER OF SOCIAL SECURITY'S PROPOSED
IMPROVEMENTS TO THE DISABILITY
DETERMINATION PROCESS**

HEARING
BEFORE THE
SUBCOMMITTEE ON SOCIAL SECURITY
AND
SUBCOMMITTEE ON HUMAN RESOURCES
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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**COMMISSIONER OF SOCIAL SECURITY'S
PROPOSED IMPROVEMENTS TO THE
DISABILITY DETERMINATION PROCESS**

TUESDAY, SEPTEMBER 27, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The Subcommittees met, pursuant to notice, at 4:10 p.m., in room 1100, Longworth House Office Building, Hon. Jim McCrery (Chairman of the Subcommittee on Social Security), and Hon. Wally Herger (Chairman of the Subcommittee on Human Resources) presiding.

The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
September 20, 2005
SS-9

CONTACT: (202) 225-9263

McCrery and Herger Announce Joint Hearing on Commissioner of Social Security's Proposed Improvements to the Disability Determination Process

Congressman Jim McCrery (R-LA), Chairman, Subcommittee on Social Security, and Congressman Wally Herger (R-CA), Chairman, Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittees will hold a joint hearing on the Commissioner of Social Security's proposed regulation to improve the disability determination process. **The hearing will take place on Tuesday, September 27, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittees and for inclusion in the printed record of the hearing.

BACKGROUND:

The Social Security Administration (SSA) administers two Federal disability programs: Disability Insurance (DI), and Supplemental Security Income (SSI). The DI program is primarily financed through Social Security payroll taxes and provides benefits to disabled workers and their families based on previous employment covered by Social Security. As of July 2005, more than eight million disabled workers and their families received \$6.2 billion in monthly benefits. By 2013, the SSA expects the DI rolls to increase by 35 percent due to the aging of the Baby Boomers. The SSI program is a means-tested income assistance program funded with general revenues. As of July 2005, about 5.9 million blind and disabled individuals received \$2.6 billion in Federal monthly SSI payments.

Growing workloads for these two programs have placed increasing demands on the SSA. Applications have increased 30 percent during the past 5 years, from 2 million in Fiscal Year (FY) 1999 to 2.6 million in FY 2004. Those who pursued their disability claims through all levels of agency appeal waited an average of 1,049 days in FY 2004 for a final decision. While the DI and SSI programs accounted for only 21 percent of benefit payments in 2004, these programs consumed more than 57 percent of the SSA's administrative resources, due to the complexity of making disability determinations.

Currently, persons seeking DI or SSI benefits must file an application with the SSA, which is forwarded to a federally-funded State Disability Determination Service (DDS) to determine whether the individual meets the medical and vocational criteria for disability. If the DDS denies the claim, the applicant has three levels of administrative appeal, including a hearing by an Administrative Law Judge, before proceeding to Federal court.

During a September 25, 2003 hearing before the Subcommittee on Social Security, the Commissioner of Social Security, Jo Anne B. Barnhart, first outlined her approach to improve the disability determination process. The Commissioner's goal is

to enhance the SSA's ability to make the correct determination as quickly as possible and to help individuals with disabilities return to work by establishing several new demonstration projects. On September 30, 2004, the Subcommittees on Social Security and Human Resources held a joint hearing to further examine Commissioner Barnhart's approach.

After 2 years of development, during which time the Commissioner solicited and received comments from many stakeholders, on July 27, 2005, the SSA published its proposed regulation to improve the disability determination process. A description of the key components of the proposed regulation can be found on the SSA's website at: <http://www.ssa.gov/disability-new-approach/factsheet.htm>

According to the SSA, these process improvements are built upon the SSA's new electronic disability folder system, will be implemented on a phased-in basis, would not require legislative action, and would reduce processing time by at least 25 percent.

In announcing the hearing, Chairman McCrery stated, "Commissioner Barnhart is to be commended for her longstanding commitment to improving the disability determination process. The proposed regulation links procedural streamlining with methods for strengthening the quality and consistency of disability decisions. This hearing gives us the opportunity to closely examine the proposed regulation, including its fairness, impact on claimants, and issues related to its implementation."

Chairman Herger stated, "The Social Security disability determination process has long been in need of improvement. I applaud Commissioner Barnhart for taking a serious look at the current process and developing a well thought-out proposal. I am interested in hearing her thoughts as well as the comments of organizations and individuals involved in the disability determination process."

FOCUS OF THE HEARING:

The Subcommittees will examine Commissioner Barnhart's proposed regulations for the disability determination process and new return-to-work demonstration projects.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "109th Congress" from the menu entitled, "Hearing Archives" (<http://waysandmeans.house.gov/Hearings.asp?congress=16>). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the on-line instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Tuesday, October 4, 2005. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

* * * **CHANGE IN TIME** * * *

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
September 21, 2005
No. SS-9 Revised

CONTACT: (202) 225-9263

Change in Time for Joint Hearing on Commissioner of Social Security's Proposed Improvements to the Disability Determination Process

Congressman Jim McCrery (R-LA), Chairman, Subcommittee on Social Security, and Congressman Wally Herger (R-CA), Chairman, Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the joint hearing on the Commissioner of Social Security's proposed regulation to improve the disability determination process, previously scheduled for 10:00 a.m. on Tuesday, September 27, 2005 in room 1100 Longworth House Office Building, **will now be held at 4:00 p.m.**

All other details for the hearing remain the same. (See Subcommittee Advisory No. SS-9, dated September 20, 2005).

Chairman MCCRERY. Good afternoon. After some technical difficulties, we will begin the hearing. Welcome, everyone, to our joint subcommittee hearing on the Commissioner of Social Security's proposed regulatory changes to the Disability Determination Process. I want to welcome all of the witnesses today, and I want to

give a special welcome to the Commissioner of Social Security, Jo Anne Barnhart. Before we get to the focus of this hearing, I do want to take a moment, Commissioner Barnhart, to ask that you take back to your employees my personal appreciation for all that they have done and are doing to help the victims of Hurricane Katrina and now Hurricane Rita.

Ms. BARNHART. Thank you, Mr. Chairman. I will do so.

Chairman MCCRERY. The stories that I have heard from my constituents and from evacuees who are in my district with regard to the Social Security Administration (SSA) are very positive. Social Security was one government agency that responded very quickly and efficiently, and gave some comfort to those who had been displaced from their homes and had no idea when they might get back or where their checks might be, and your agency's response in getting replacement checks to those folks was very, very welcome, so thank you for doing that.

Ms. BARNHART. Thank you.

Chairman MCCRERY. Turning now to the subject of the hearing today, this hearing represents an important milestone in a journey that began about 2 years ago when the Commissioner made a commitment during a hearing before the Subcommittee on Social Security to improve the agency's disability determination process. Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs provide important benefits for the most vulnerable people in our country. Sadly, for many, circumstances worsen as they wait for a final decision on their claim. Others do not fully pursue their appeal options because the process is too complex. Fortunately, Commissioner Barnhart has done more than merely talk about the need to improve the disability determination process, she has taken action.

The accelerated implementation of the electronic disability folder system, or eDib, is just one example. The proposed regulation we examine today is another step forward in the question for meaningful reform. While no regulation can please everyone, I believe this one has many merits. I also hope the Commissioner will be open to the thoughtful suggestions for regulatory improvements that we will hear from our second panel today. As we proceed, I hope we will all remember that we have the same goal, an improved disability determination process that will truly serve those with disabilities and their families. I look forward to hearing from the Commissioner and our distinguished panel. As I said, this is a joint Subcommittee hearing, and I would ask the distinguished Chairman of the Subcommittee on Human Resources, Mr. Herger, for his comments.

[The opening statement of Mr. McCrery follows:]

Opening Statement of The Honorable Jim McCrery, Chairman, Subcommittee on Social Security, and a Representative in Congress from the State of Louisiana

Good afternoon and welcome everyone to our joint Subcommittee hearing on the Commissioner of Social Security's proposed regulatory changes to the disability determination process.

I want to welcome all of our witnesses today and to give a special welcome to the Commissioner of Social Security, Jo Anne Barnhart.

Before we get to the focus of this hearing, I would like to take a moment, Commissioner Barnhart, to ask you to take back to your employees my personal apprecia-

tion for all they have done and are doing to help the victims of Hurricane Katrina and now Hurricane Rita. In spite of the personal trauma caused by these hurricanes, Social Security employees have been hard at work to ensure that eligible evacuees received and will continue to receive their Social Security payments whether they're living in a temporary shelter in the Gulf region, or staying with relatives or friends elsewhere in the country. Your employees have exemplified excellence in public service—going far beyond the call of duty to serve those in dire need.

Turning to the subject of our hearing, today represents an important milestone in a journey that began two years ago, when you made a commitment during a hearing before this Subcommittee to improve your agency's disability determination process.

The Social Security Disability Insurance and Supplemental Security Income programs provide important benefits for the most vulnerable people in our country. Sadly, for many, circumstances worsen as they wait for a final decision on their claim. Others do not fully pursue their appeal options, because the process is too complex.

Fortunately, Commissioner Barnhart has done more than merely talk about the need to improve the disability determination process—she has taken action. The accelerated implementation of the electronic disability folder system or “e-Dib” is just one example. The proposed regulation we examine today is another step forward in the quest for meaningful reform. While no regulation can please everyone, I believe this one has many merits. I also hope the Commissioner will be open to the thoughtful suggestions for regulatory improvements that we will hear today.

As we proceed, let us remember that we all have the same goal—an improved disability determination process that will truly serve those with disabilities and their families.

I welcome our distinguished panel, and I look forward to hearing their views.

Chairman HERGER. Thank you, Chairman McCrery. I would like to take a moment to join in thanking you, Commissioner Barnhart, and the other witnesses that we will be hearing today. In addition I want to thank Mr. McDermott and the other Members for working on a bipartisan basis on H.R. 3672, the McCrery-Jefferson Hurricane Relief legislation. I know the Commissioner has been leading an aggressive effort to make sure that those in disaster areas are receiving their Social Security benefits. I thank you, and I thank your staff for your hard work in meeting this extraordinary challenge. With that, I will submit my full statement for the record of today's hearing and yield back the balance of my time.

[The opening statement of Mr. Herger follows:]

Opening Statement of The Honorable Wally Herger, Chairman, Subcommittee on Human Resources, and a Representative in Congress from the State of California

It is with great interest that I join my colleagues on the Social Security Subcommittee in welcoming Commissioner Barnhart and our other witnesses to the hearing today. We will receive testimony on the proposed rule to implement the Commissioner's plan for improving the Social Security Administration's disability determination process.

It was just about a year ago that we met in this same room to gather input on the Commissioner's plan. At that hearing we learned that some parts of the plan, such as the Quick Disability Decision step, were generally well received and that other suggestions, such as closing the record at the end of the process, were greeted with less enthusiasm. Since then the Commissioner has continued her review of the process and the comments she received from her many discussions with interested groups as she developed the proposed rule.

We all know that Social Security disability programs touch millions and provide a safety net for many needy disabled individuals. We've all heard from constituents who waited months or years to learn the outcome of their application for disability benefits. And we all are interested in improving the Social Security disability determination process to better serve these individuals. The Commissioner is to be commended for her leadership in making great strides towards that goal.

She also deserves credit for accelerating the introduction of electronic folders into the disability determination process. This action allows work on a claim to proceed more quickly since time consuming steps such as mailing a folder back and forth between offices has been eliminated. It has paid dividends in times of crisis as well. For example, the advent of electronic folders has allowed cases in hurricane ravaged states to continue moving through the disability process in spite of damaged buildings, missing paper records, and displaced workers.

The Commissioner's Work Opportunity Initiative is another area of particular interest to me. I am interested in hearing more about this initiative and getting an update on implementation of the demonstration projects. I thank the Commissioner for her efforts in this area, too.

I look forward to all the testimony we will receive today from witnesses with expertise in so many different stages and aspects of the disability determination process.

Chairman MCCRERY. Thank you, Mr. Herger. Now the distinguished Ranking Member of the Social Security Subcommittee, Mr. Levin.

Mr. LEVIN. Thank you very much. I, Mr. McCrery, join you in the spirit and the substance of your remarks, and also you, Mr. Herger, and I am sure my colleague and friend, Mr. McDermott. Clearly, everybody believes in improving this system. We have, what, 1,300,000 cases pending? I think that was the latest figure I was given, and a long period of time for cases to be decided, and you decided to grab this problem by the back of the neck and take a hard look at it. Now you are achieving at long last an electronic system—though I am a little behind my grandchildren in modern technology, and some of them are quite young—it is good we are catching up in this government.

So far, as I understand it, while there has been widespread discussion, it has been more internal than external, and now with the regulations before us, hopefully this will be the beginning of even more vigorous two-way communication. Just very briefly, because you want to get on with your testimony and the other panel. Some of the regulation's aspects clearly make sense, the 20-day processing provision, having more expertise in disability law at the very first level of appeal, and also having a network of highly trained medical and vocational experts. There are—and I think Mr. McCrery referred to it—some serious concerns about some aspects of the regulations, the proposed regulations, and new obstacles, for example, to appeals, and in some cases reductions in beneficiary rights, and last, some changes that might lead to a less completed evidentiary record. We are going to hear the second panel talk about that, and also perhaps you, Commissioner, will talk about what you think are some of the question marks as well as the many strengths. We look forward very much to your testimony.

Chairman MCCRERY. Thank you, Mr. Levin. Now for the concluding opening statement, the distinguished Ranking Member of the Subcommittee on Human Resources, the gentleman from Washington, Mr. McDermott.

Mrs. TUBBS JONES. Excuse me. We will all be able to submit opening statements for the record?

Chairman MCCRERY. Yes, ma'am, without objection.

Mrs. TUBBS JONES. Thanks.

Chairman MCCRERY. Dr. McDermott.

Mr. MCDERMOTT. Mr. McCrery and Herger, thank you for calling this hearing to seek additional comments on the Social Security Administration (SSA) Commissioner's proposal. I believe our goals should be to help people by streamlining the process and speeding up the decisionmaking without compromising the integrity of the system, and I think the Commissioner's proposal recommends some very important improvements, like the fast track for obvious cases of disability and using a national network of medical and vocational experts to improve the quality of disability evaluations. These are good ideas and the Commissioner deserves credit for offering them.

However, as currently written, I think we would be ill advised to support these proposed regulations because they turn claimants into defendants. I have been in these proceedings and I know a little bit about them, and the outcome will harm the very people I think we are trying to help. I am particularly concerned about the new rules as they relate to submitting evidence during the appeals process and requesting that a case be reconsidered in the event that new evidence becomes available at a later time. I am concerned about the potential of these proposed regulations as they apply to children applying for SSI. Like other beneficiaries, if a child's parent cannot adhere to all the new rules under the proposal, that child will simply not receive critical assistance that they need in their early years, and beyond that, the proposed new rules ignore the unique characteristics of the population that is served by SSI and disability programs.

Some of these recipients suffer from the very severe disabilities that make it difficult for them to complete the disability claims on their own. Meanwhile, others who suffer from disabilities that are not easily identified, such as multiple sclerosis, will have difficulty meeting the new deadlines for submitting medical evidence, and will face additional obstacles in getting their cases reopened after the appeals process is completed. As written, these regulations make due diligence unduly difficult. People will fall through the safety net. People will get hurt, and I really don't want to be a part of seeing a child hurt because we approve new regulations that put the bureaucracy's efficiency against what really goes on in the world.

I appreciate the Commissioner's initiative to improve the disability process, but I think there is more that needs to be done, and I am looking forward to hearing the comments of the witnesses here today, because I think we all want the same thing. It is really a question of how do we get to it. I don't expect this to be confrontational. I expect it really to be a discussion about what will actually work, because having sat in these hearings as an expert witness on occasion, I have lots of feelings. Thank you.

Chairman MCCRERY. Thank you, Dr. McDermott. Commissioner Barnhart, please proceed. As you know, your written testimony will be submitted in its entirety for the record, and if you can summarize that in about 5 minutes, we would appreciate it. Likewise, for the Members of both Subcommittees, anyone wishing to present an opening statement can certainly do so in writing, and it will indeed be included in the record without objection. Commissioner Barnhart, welcome.

**STATEMENT OF JO ANNE B. BARNHART, COMMISSIONER,
SOCIAL SECURITY ADMINISTRATION**

Ms. BARNHART. Thank you, Mr. Chairman. I am pleased to be here today to discuss my approach to improve the Social Security disability claims process. Chairman McCrery, Chairman Herger, Mr. Levin and Mr. McDermott, and Members of the Subcommittees, I really appreciate your interest and support for our programs. When I accepted the job of Commissioner I made it clear that I did not accept this position to manage the status quo, and nowhere was the need for change more apparent than in the disability process. Therefore, I made improving service to our disability claimants a priority. It has been clear to me from the beginning that we need to make some significant changes to the process if we are going to provide the kind of service that the American people expect and deserve.

As you know, we have taken a number of steps to that end already, most notably the successful implementation of the electronic disability process. The notice of proposed rulemaking (NPRM), which is the subject of this hearing, is I believe the next step. Before I go any further, I do want to take a moment to elaborate on the Chairman's comments about Hurricane Katrina, and address the SSA's role in the national response to the devastation that was left in the wake of Hurricane Katrina.

We are still assessing the impact of Hurricane Rita, but we anticipate using the same procedures I am going to describe that we employed for Hurricane Katrina, where it is necessary to respond to the needs of those affected by Hurricane Rita. Foremost, I want you all to understand that we are doing all that we can to make sure that beneficiaries and recipients are receiving their benefits. To meet the needs of beneficiaries affected by Hurricane Katrina, I invoked immediate payment procedures that provide for on-the-spot checks at any SSA office around the country.

Within a few days of the hurricane we knew there was no way for many of our beneficiaries to reach our offices, so for those who relocated to evacuation centers or shelters, as the Chairman mentioned, such as the Astrodome, or in Baton Rouge, SSA established an onsite presence, and we have already issued more than 53,000 immediate payments. Clearly, with the complete devastation of Hurricane Katrina, many citizens did not have identification. To make sure that evacuees have the Social Security information that is necessary for employment, for other Federal assistance, to sign a lease to rent an apartment or a new home, SSA staff are assisting individuals through a simplified protocol to get them the documentation they need, whether it is the benefit amount or a verification of their Social Security number.

Our dedicated employees are at the core of our efforts. The men and women of SSA, many of whom themselves have lost their own homes, have in fact worked long hours, and in some instances slept in offices and commuted over long distances to make sure that those on the Gulf Coast were receiving the help that they need. I am incredibly proud to lead an agency with the spirit and the compassion that is the character of our Nation's SSA employees. Our work today continues in shelters and in field offices everywhere in the country where there are evacuees. It continues with file recov-

ery, establishment of temporary offices and work toward repairing damaged buildings. It continues through our commitment to making sure that the pending disability claims of people who were affected by Hurricane Katrina are completed as timely as possible.

In order to leave as much time for questions as possible this afternoon, I won't take time to describe the proposed rules on the new approach in my oral statement, but I do want to say that I believe we have a unique opportunity to make changes that will substantially improve the disability process. This NPRM is the blueprint for what began as a conceptual framework 2 years ago. As I promised last year, we have conducted an open outreach process to get ideas from those involved in every aspect of the disability determination process. I want to thank everyone who shared their views and those who plan to submit comments on the NPRM. I am looking forward to reviewing those comments, and I fully expect that just as there were changes from concept to NPRM, there would be changes from the NPRM to the final rules.

I didn't expect that everyone would embrace every element of the process that is proposed in the NPRM, but I do hope that when we review the comments, we will continue to see the same cooperative and constructive spirit that has characterized the discussions we have had over this past year. Certainly, the testimony of the other witnesses today, which I read last evening, suggests that we are off to a very good start. I want to emphasize my personal commitment to reviewing the comments in that spirit. Before I close, I would like to again acknowledge the hard work and dedication of our SSA and State Disability Determination Services employees. The current backlogs and associated delays exist despite their best efforts. Finally, I would like to again acknowledge the support and guidance of the Members of these Subcommittees. Your leadership and your interest have played a significant role in our ability to get people from all perspectives to work together in this effort. Thank you, Mr. Chairman. I will be happy to try and answer any questions that you or the other Members may have at this time.

[The prepared statement of Commissioner Barnhart follows:]

Statement of The Honorable Jo Anne B. Barnhart, Commissioner, Social Security Administration

Chairman McCrery, Chairman Herger and Members of the Subcommittees:

Thank you for inviting me today to discuss my approach to improve the Social Security disability claims process. Throughout my tenure as Commissioner, I have made improving the disability determination process one of my highest priorities.

As I have discussed in previous appearances before you, we have taken a number of steps toward that end—especially the successful implementation of the electronic disability process. And I want to thank the Members of the Subcommittees for your support of our efforts. It has been clear to me from the beginning that we need to make some significant changes to streamline the system if we are to provide the kind of service the American people expect and deserve.

But before I go any further, I want to take a moment and address Social Security's role in the national response to the devastation left by Hurricane Katrina. Foremost, I want you to know that we are doing all that we can to make sure that beneficiaries are receiving their benefits.

Approximately one million Social Security and Supplemental Security beneficiaries live in the affected counties or parishes of Louisiana, Mississippi and Alabama. And every month, they receive almost a billion in benefits.

To meet the needs of these beneficiaries, I invoked immediate payment procedures which permit payments to be made to any Social Security beneficiary or Supplemental Security Income recipient who has lost access to their benefit check. This

means that beneficiaries from the Gulf Coast can go to any Social Security office throughout the United States and request an immediate payment, and a check will be issued on the spot.

Within a few days of the hurricane, we knew that there was no way for many of our beneficiaries to reach one of our offices. So, for those who relocated to evacuation centers or shelters, Social Security established an on-site presence to issue immediate replacement checks.

We have already issued about 53,000 immediate payments. To put this in perspective, in a typical month a district office provides an average of 8 immediate payments, but in a single day we issued almost 200 at the Astrodome alone. We hope to have new addresses for as many people as possible for the October checks, but will still issue immediate payments for those who need them.

We're also working with Federal, State and local officials in affected areas to assist families who—after the hurricane—may *now* be eligible for Social Security benefits. In this regard, we have put into place emergency procedures that will enable us to quickly process applications for survivors—widows, widowers and their children—or other Social Security benefits.

Clearly with the complete devastation of Hurricane Katrina, many citizens do not have identification. To make sure evacuees have the Social Security information necessary for employment or other Federal assistance, SSA staff are assisting individuals through a simplified protocol to get them the documentation they need.

Our dedicated employees are at the core of our efforts. When I had the opportunity to visit the Gulf Coast, I saw in person the professionalism and compassion of the men and women of SSA and the State Disability Determination Services. There has been a tremendous outpouring of support from these employees. These dedicated men and women, many of whom have lost their own homes and face other losses related to Hurricane Katrina, are working long hours, and in some instances sleeping in offices and commuting over long distances to make sure that those on the Gulf Coast are receiving the help they need. I am incredibly proud to lead an agency with the spirit and the compassion that is the character of our nation's Social Security employees.

For example, in Mobile, an employee delivered an immediate payment check to a local shelter and stayed to help serve dinner. Later that night, she returned to donate items for a baby staying at the shelter. I am sure there are countless other stories like this that remain to be told.

Our work continues in shelters and in field offices everywhere in the country where there are evacuees. It continues with file recovery, establishment of temporary offices, and work toward repairing damaged buildings. And it continues through our commitment to making sure that the pending disability claims of people who were affected by Hurricane Katrina are completed as timely as possible.

We have retrieved all of the 6,321 paper files from the New Orleans Disability Determination Services (DDS) office. With a special pass arranged by the Office of the Inspector General, we gained entry into the DDS building in New Orleans, packed 400 boxes of files, which contractors carried down many flights of stairs lit only by flashlights. We will make sure these cases are processed as soon as possible.

In previous appearances before you, I've stressed the importance of our electronic disability process—eDib—which is replacing voluminous paper files with electronic files. Electronic files had been established for about 1,900 of the cases pending in the New Orleans DDS office. I'm pleased to report that we electronically reassigned these cases to the Shreveport office of the DDS beginning in the first week of September.

This brings me back to our topic today—how to make major improvements in the disability process so that we can provide better service to all Americans who apply for benefits.

Status of eDib

When I first discussed with you my new approach to the disability process, I said that the foundation for the new approach was successful implementation of eDib.

The new approach to disability claims processing can work efficiently only when all components involved in disability claims adjudication and review move to an electronic business process through the use of an electronic disability folder.

I am pleased to say that eDib is becoming a reality across the nation.

As planned, rollout is being staggered to ensure that SSA is able to provide each DDS with the support necessary for successful implementation. Once rollout begins in a DDS, the number of DDS decisionmakers working with electronic folders gradually expands as the DDS develops expertise with the process. So far, 53 of the 54 DDSs in 49 out of the 50 States have rolled out the electronic disability folder,

which means that some or all of the decisionmakers in these DDSs are adjudicating cases in an electronic environment.

In January 2004, the Mississippi DDS started implementing eDib. This past January, the Mississippi DDS became the first in the nation to start processing virtually all cases in a totally electronic environment. Since eDIB was fully implemented in the Mississippi DDS, the DDS has reduced its processing times for Title II disability claims by 7.1 days and for Title XVI disability claims by 9.8 days. Hawaii, Illinois, and Nevada have joined Mississippi and are processing all new disability claims in a totally electronic environment. We are reviewing the progress being made in several other States and by the end of the year another 13 DDSs may be totally electronic.

At the Office of Hearings and Appeals (OHA), our Case Processing and Management System has been implemented in all of the hearing offices and is being used to control case flow and provide management information. In addition, 79 hearing offices in 26 States have conducted over 700 hearings using electronic folders. The initial response from OHA's Administrative Law Judges, and claimants and their representatives has been positive.

In addition, we have been replacing all of our hearing offices' aging tape recorders with digital recording equipment. This equipment is less bulky than the old analog equipment and offers enhanced quality, more stable storage capacity, and greater business process functionality. Furthermore, it provides an electronic recording that eventually will be stored in the electronic folder. Currently, digital recording has been installed in 8 regional offices and 106 hearing offices. We expect all hearing offices to be converted to digital recording by April 2006.

By the end of next year, I expect each of the DDSs and OHAs to be processing their workloads with electronic disability folders on a regular basis. As I noted earlier, eDib allows SSA and DDS adjudicators to view an individual's claims file anywhere in the country. This flexibility affords SSA a new opportunity to make changes to improve the administrative efficiency of the program.

The New Approach

Last year, I testified before you on my vision for the new approach to disability determination. I described to you a conceptual framework for the new approach, and I promised that, before we published proposed rules to turn the conceptual framework into a comprehensive plan, we would conduct an open consultation process to hear from those involved at every step of the disability process.

As you know, on July 27, we published a Notice of Proposed Rulemaking (NPRM) which sets out my plan to improve the disability determination process. This NPRM was developed after an extensive outreach program I launched to let interested parties know what I was considering and to listen to their reaction. I personally conducted over 100 meetings with almost 60 groups, both internal and external. My staff participated in many more meetings. We also received hundreds of emails from individuals currently receiving disability benefits, individuals currently applying for benefits, and other interested citizens providing recommendations on how to improve the process.

As a result of these discussions, the NPRM includes significant changes to the framework I originally put forth. For instance:

- We initially believed that Quick Disability Determination claims should be adjudicated in regional units across the country, and not in the State agencies. However, many of the groups we met with and numerous individuals believed that the State agencies could effectively adjudicate these claims. In the NPRM, we have proposed that the State agencies be allowed to adjudicate Quick Disability Determination claims.
- Several organizations and numerous individuals also urged us to allow the State agencies to continue to use State agency medical consultants when making initial disability determinations under the proposed plan. The NPRM provides that State agencies may continue to use State medical and psychological consultants in the disability determination process, as long as they meet SSA's qualification standards in those areas where standards have been established.

A number of the groups we spoke with asked that we consider providing for good cause exceptions to closing the record after the issuance of the ALJ decision. Although the NPRM proposes to close the administrative record after the ALJ issues his or her decision, it also provides for limited good cause exceptions to closing the record.

Another area of concern involved our plans to eliminate the Appeals Council step of the administrative review process. For example, some thought that if claimants could not request administrative review with the Appeals Council, the Federal

courts would see a large influx of Social Security disability cases following the ALJ hearing level. Accordingly, a number of organizations and groups asked us to retain the Appeals Council until we could be sure that the proposed new process was working as intended.

The NPRM makes it clear that we intend to roll out the new process gradually on a region-by-region basis, and that we also intend to retain the Appeals Council and continue its operations in those regions where the new process has not yet been implemented. This gradual implementation also will provide us with the opportunity to assess the effects of the elimination of the Appeals Council and to make any necessary adjustments.

The Objective of the Changes we have Proposed

My objective in proposing changes in SSA's disability determination process is to fundamentally improve the quality of service that the agency provides both to claimants and to the public at large.

When I first spoke with President Bush about the current disability program, he asked me three questions. Those questions were:

- Why does it take so long to make a disability decision?
- Why can't people who are obviously disabled get a decision immediately?
- Why would anyone want to go back to work after going through such a long process to receive benefits?

I realized that designing an approach to fully address the central and important issues raised by the President required a focus on two over-arching operational goals:

1. to make the right decision as early in the process as possible; and
2. to foster return to work at all stages of the process.

To accomplish this, the NPRM proposes changes aimed at expediting the disability decisionmaking process; improving the accuracy, consistency, and fairness of decisions; and making the process more understandable and more credible. We are also working on a series of demonstration projects that we believe will help us determine how best to assist disabled individuals in their efforts to participate in the Nation's workforce.

Before I describe some of the features of the NPRM, I want to take a moment to talk about what I believe is a unique opportunity to make the kind of changes that will substantially improve the disability process. This is a difficult challenge because people who view the process from different vantage points, have different perspectives, and different views on what we should do to improve it.

I think this is one reason that past efforts have not been successful. But, this time, I believe that we can be successful. I say this because of the spirit of cooperation, openness, and constructive dialogue that I have seen in the conversations we've had with people involved at every stage of the process.

As I said a moment ago, this NPRM is the blueprint for what began as a conceptual framework for our new approach. I do not expect that everyone will embrace every element of the process proposed in the NPRM. I am looking forward to reviewing those comments and fully expect that there will be changes from the NPRM to the final rules. I do hope that when we review the comments, we will continue to see the same cooperative and constructive spirit and that we can focus on the ultimate goal of improving the process from start to finish.

Before I go any further, I would like to acknowledge the hard work and dedication of our SSA and State Disability Determination Services (DDS) employees. The current backlogs and associated delays exist despite their best efforts. I want to emphasize that no Social Security or State employee will be adversely affected by my new approach. I believe the new approach will allow them to provide even better service to the public.

The proposed regulations do preserve some of the significant features of the current system. Initial disability claims will continue to be handled by SSA's field offices; State DDS agencies will continue to adjudicate claims for benefits; and Administrative Law Judges (ALJs) will continue to conduct *de novo* hearings and issue decisions. However, the proposed regulations also make some important changes. Today I would like to talk about the major changes we have proposed and why we have proposed them.

Quick Disability Determination Unit

The proposed rules would establish a Quick Disability Determination (QDD) process through which State agencies would expedite cases for people who are clearly disabled. Appropriate claims would be identified and referred directly to special

units in the State agencies. We expect that these QDD units would then process these claims in 20 days or less, thereby potentially reducing waiting times for those claimants by several months.

Federal Expert Unit

We realized that under our current disability adjudication process, medical and vocational experts are not consistently available to adjudicators at every level or in all parts of the country. Therefore, we proposed to create a Federal Expert Unit to oversee a national network of medical, psychological, and vocational experts that will be available to assist adjudicators at all levels throughout the country. The purpose of this Federal Expert Unit, would be to augment and strengthen the medical and vocational expertise that currently exists in our DDS's. State medical consultants can choose to become part of the Federal Expert Unit if they meet the qualifications. And, as we have said before, we want to ensure that each case is seen by the right medical eyes. For example, an adjudicator evaluating a musculoskeletal impairment would be able to receive an orthopedist's opinion before deciding the claim, thus ensuring a more accurate decision. Presently, 20 percent of the disability workload is comprised of musculoskeletal cases, yet only 2.5 percent of DDS medical consultants are orthopedists.

Eliminate State Agency Reconsideration and Create Federal Reviewing Officials

Several of the groups and individuals with whom we met described the reconsideration review level in the disability process as having little value. Based on the belief that claimants perceive this level as little more than a rubber stamp, the proposed regulations would eliminate the reconsideration level of review. State agency examiners would be required to more fully document and explain the basis for their determinations at the initial level. We would create a Federal reviewing official (RO) who would review initial State agency denials if a claimant appealed. The RO would provide a written decision on the claim, give reasons for accepting or rejecting findings, and consult with an expert affiliated with the national network if he or she disagrees with the initial determination.

During the course of our outreach, as we discussed this appeals step, people told us that the RO does not need to be an attorney about as often as others told us that the RO absolutely should be an attorney. As we indicated in the NPRM, we believe that attorneys are ideally suited to perform certain critical RO functions, such as drafting well-supported, legally-sound decisions. Moreover, we believe that using attorneys will improve the level of confidence in the integrity of this level of review. Therefore, we have proposed filling this position with attorneys. As these Subcommittees are well aware, we already employ many excellent attorneys who have significant experience in SSA's disability programs.

Retains the de novo Hearing Before The Administrative Law Judge (ALJ)

ALJs would continue to hold *de novo* hearings and issue decisions based on all the evidence presented during the hearing. ALJs would not be required to give any legal deference or weight to the decisions previously made by the RO; however, ALJs would be required to provide in their decisions an explanation as to why they agree or disagree with the rationale in the RO's decision. This explanation would be used to provide constructive feedback to reviewing officials to improve future case reviews.

Submitting Evidence Timely and Closing the Record

Throughout our discussions, there was a general concern that we need to receive claimants' evidence in a more timely manner. The NPRM proposes that claimants must submit evidence no later than 20 days before the hearing. Furthermore, the record would close after the ALJ issues a decision. We believe that these changes will increase our ability to process hearing requests in a more timely manner.

Similarly, we heard from a number of people who were concerned that these new changes would harm those claimants who, through no fault of their own, were unable to submit their evidence in a timely manner. The NPRM proposes closing the record but includes good cause exceptions to the submission requirements I have just described.

These proposed changes would protect a claimant's right to fairly present his or her case while reducing unnecessary delays in the hearing process.

Decision Review Board (DRB)

Under the proposed rules, Appeals Council functions gradually shift to a newly established Decision Review Board (DRB). The DRB would review both allowances and denials. A claimant's right to request review of an ALJ decision in a disability

claim would be eliminated; however, a claimant could still seek review when an ALJ dismisses his or her request for a hearing.

The DRB would consist of both ALJs and Administrative Appeals Judges serving staggered terms who would review both favorable and unfavorable decisions that are likely to be error-prone. As I mentioned, the disability review functions currently performed by the Appeals Council would gradually shift to the DRB as the new approach is implemented region by region.

One of the concerns related to elimination of the Appeals Council was the possibility of an increase in court workloads. The NPRM proposes to gradually eliminate the Appeals Council only in those regions where we have implemented the changes in the NPRM. We will monitor the cases appealed to the Federal District Court, and the gradual rollout allows us to make adjustments as necessary.

Quality

The NPRM addresses the need for in-line and end-of-line quality review at all levels of the disability determination process. Pre-effectuation review at the initial level would continue.

The lynchpin of quality assurance under the new approach is accountability and feedback at each level. The new quality process would focus on both denials and allowances, and concentrate on ensuring that cases are fully documented at each stage. This last point is crucial because we believe that better documentation would allow cases to move through the system more quickly and will produce better decisions.

Demonstration Projects

Currently, we have numerous incentive programs that encourage disability beneficiaries to work, such as the Ticket to Work and Self-Sufficiency program and expedited reinstatement. Despite these incentives, few disability beneficiaries choose to work.

We have designed several demonstration projects to test the impact of different work incentives on disability beneficiary and claimant behavior. These projects include the following:

Accelerated Benefits Demonstration Project. This demonstration project will provide immediate private health benefits and employment supports for a specified period (2 to 3 years) to newly entitled SSDI beneficiaries who are highly likely to improve medically with aggressive medical care. For instance, a new beneficiary with a fractured hip would benefit from immediate health care to facilitate a return to the workforce. We expect to award a contract for this project within a month and to begin enrolling participants next year.

National Benefit Offset Demonstration Project (\$1 for \$2). This demonstration will test the effects of allowing Disability Insurance beneficiaries to work without total loss of benefits by reducing their monthly benefit one dollar for every two dollars of earnings above a specified level. While the contractor for the national demonstration project is designing the project, we are operating a smaller four-state benefit offset demonstration in Connecticut, Utah, Wisconsin, and Vermont. This four-state project will help inform the national demonstration project. These projects are well underway and the States began enrolling participants in August 2005.

Early Intervention Demonstration Project. This project would provide immediate medical and cash benefits as well as employment supports to SSDI applicants with certain impairments presumed disabling who elect to pursue work rather than proceed through the disability determination process. We will be conducting this demonstration as a part of our National Benefit Offset project.

Mental Health Treatment Study. The purpose of the Mental Health Treatment Study (MHTS) is to study the impact that better access to medical treatment and employment services would have on outcomes such as medical recovery, and ultimately employment for SSDI beneficiaries who have a mental impairment as a primary diagnosis. The project will provide outpatient treatments (pharmaceutical and psychotherapeutic) and/or employment support services. The interventions will be implemented through demonstration projects in multiple sites. SSA awarded a contract to the Urban Institute to develop and administer a 10-member Technical Advisory Panel (TAP), consisting of experts in the fields of psychology, psychiatry, research, private insurance, and employment supports. The final report was issued in April 2005 and provided recommendations for appropriate interventions for this population. We expect to award a contract for this project this year with enrollments starting next year.

Youth Transition Demonstration. In September 2003, to further the President's New Freedom Initiative goal of increasing employment of individuals with disabilities, SSA awarded cooperative agreements to six States (California, Colorado,

Iowa, New York, Maryland, and Mississippi) for the purpose of developing programs to assist youth with disabilities to successfully transition from school to work. These projects are beginning their third year of operation, have enrolled 622 participants to date, and have successfully helped many youth to obtain jobs.

Disability Program Navigator. In September 2002, SSA and the Department of Labor's (DOL) Employment and Training Administration collaboratively funded a 2-year pilot of the Disability Program Navigator (DPN). As of August 2005, 267 DPNs operate in 17 States (Arizona, California, Colorado, Delaware, Florida, Illinois, Iowa, Maryland, Massachusetts, Mississippi, New Mexico, New York, Oklahoma, Oregon, South Carolina, Vermont, and Wisconsin). The Department of Labor recently announced its intention to add DPNs to 15 more States and the District of Columbia.

DPNs work in one-stop career centers where beneficiaries with disabilities can receive employment services. The purpose of the Navigators is to provide a connection between beneficiaries and jobs through the local workforce investment boards.

California HIV/Immune Disorder Demonstration Project

The purpose of the California HIV/Immune Disorder Demonstration Project is to determine whether immediate and ongoing comprehensive medical benefits along with employment service coordination helps to improve the health of participants to enable them to increase their economic self sufficiency through work. SSA plans to work with the California Department of Rehabilitation (DOR) to provide employment services coordination so that participants will have ongoing supports throughout the process to facilitate an employment goal. Also, SSA will provide DOR with a network of California medical expertise that will provide assistance in developing employment plans that are consistent with limitations or needs associated with the individual's impairment. SSA will provide the funding for services provided by DOR and the medical network.

This is the first time that such a unique approach will be tested, i.e. Federal and State entities working collaboratively with the medical community for purposes of helping individuals with disabilities return to work. SSA will evaluate the impact these changes have on beneficiaries' health, work behavior, and dependency on long-term benefits.

We expect to begin enrolling participants in calendar year 2006.

Next Steps

As I said earlier, we published the proposed regulations on July 27. The 90-day comment period closes on October 25. Again, Mr. Chairman, I want to emphasize my personal commitment as well as that of the agency to review comments in the spirit that has characterized this entire process with the expectation that there will be changes in the final rule.

I am committed to making sure that implementation proceeds carefully so that all claims are handled fairly and responsibly. We expect to begin roll-out next spring in one of our smaller regions.

Just as we did with e-Dib—as we gain experience—we will gradually roll out the process nationwide, making modifications as needed.

Conclusion

When I accepted the job of Commissioner, I made it clear that I did not accept this position to manage the status quo. Nowhere was the need for change more apparent than in the disability process. Therefore, from the outset I made improving service to our disability claimants a priority.

I want to thank everyone who has shared their views and those who plan to submit comments. Finally, I would be remiss if I did not thank you Chairman McCrery and Chairman Herger and the Members of your Subcommittees for your support and guidance. Your leadership and interest have played a significant role in our ability to get people from all perspectives to work together. I look forward to continuing to work with you and your staffs as we improve service to individuals with disabilities.

Chairman MCCRERY. Thank you, Commissioner Barnhart. Lest anyone think that my compliments to your agency for their efforts following Hurricane Katrina and now Hurricane Rita was some kind of blanket endorsement of all Executive agencies' response at the Federal, State, and local level, let me hasten to add that your

agency stood out as perhaps an exception to the rule as being very responsive. I just wanted to make that clear. One thing that is related to this issue of getting a determination as quickly as possible for people who need these benefits, I understand you have talked with Ways and Means and Finance Committee staff about a legislative proposal to enhance your agency's ability to obtain medical evidence.

Right now, even though there doesn't appear to be any requirement in the law that an original copy of those documents, of the release form which would allow those documents to be sent to the SSA, is required, there are some providers who are insisting upon getting that. You are talking about introducing a piece of legislation that would allow a photocopy or some other type of faxed copy to be used by your agency if you certify that it is a copy of the original. Is that right, and how is that going?

Ms. BARNHART. That is absolutely correct, and it is very important for us—and let me, if I could just give you an example of why it is particularly important. It would be wonderful under any circumstances to be able to encourage medical evidence being submitted electronically, particularly in light of the fact that so many evacuees and people who have applied for disability may be in the process of having their claim working through the system and we need to get additional medical evidence. They may have left their home. They have gone to a new location. The case was being worked in one of our Louisiana offices or one of our Texas offices, but they could be anywhere across the United States, continuing to receive medical evidence. It, obviously, logistically and timing wise can slow things down quite a bit if we have to provide that original signed piece of paper.

Chairman MCCRERY. Great. I want to commend you for reaching out to stakeholders in this whole issue of disability determination. Many of the improvements in your proposal have been generally well received, including quick decisions by Disability Determination Specialists (DDS), Federal Medical Vocational Expert Units, elimination of DDS reconsideration step, creation of a Federal reviewing official (RO), strengthened quality reviews, and the Return to Work demonstration projects. Would you talk more though about the collaborative efforts that you employed during this process to try to reach a proposal that gained the widest possible acceptance?

Ms. BARNHART. Yes, sir. We reached out to individuals and organizations from all aspects of the disability process. I personally conducted, I think it was 123 meetings or attended 123 meetings, where there were 58 different groups of people, both internal and external. In fact, I am pleased to say that with the exception of Dr. Bloch—not pleased I didn't meet with Dr. Bloch, but pleased to say there was just the exception of him—I actually have had several meetings with all the witnesses in the next panel during the past year to get their perspectives as well.

We also set up a website where individuals, and most notably claimants, people who were working their way through the process or who had already had the experience themselves, gave comments and suggestions. We received over 800 of those on our website as well. The head of our Disability Service Improvement Organization,

which I tasked with making sure that we did adequate outreach as we developed our proposal, directed by Mary Chatel and the Office of Disability Income Security Programs directed by Deputy Commissioner Martin Gerry, met with dozens more groups than I did, and had literally probably another 100 or so meetings themselves.

Again, we did everything that we could think of to reach out, to make sure that we were getting the perspective that would represent every step along the way as a claim moves through the process from beginning to end. I do want to take this opportunity to say again that the cooperative spirit that we found throughout every one of those encounters was really nothing short of remarkable. Many of the people have so much knowledge and expertise, which augments the personal experience of claimants. It was extremely valuable that everybody came together in a really constructive way to discuss these very difficult and complicated issues.

Chairman MCCRERY. Do you expect that kind of collaboration to continue prior to final regulations being published?

Ms. BARNHART. I absolutely do. In fact, as I said, the NPRM reflects moving from a concept to a blueprint, and we made changes, there are significant changes that were made from the new approach as I originally described it to this Committee 2 years ago, and I certainly would anticipate that there would be changes as we move from an NPRM to a final regulation. Just as I indicated in my opening statement, the spirit with which I will entertain comments, which is to look at them openly and with great interest, and certainly with the ultimate goal being to get the best system that we can get, I was so impressed when I read the testimony of all the witnesses who will follow me today, because they seem to be offering their comments in exactly that same spirit.

Chairman MCCRERY. Good. Obviously, in developing this proposal, you are trying to balance the desire of all of us to get a quicker determination for people who need these benefits, but at the same time you have to balance that with ensuring fairness in the process, and ensuring due process rights. Obviously, some—and Dr. McDermott talked about some issues that he has with your proposal—and some of the witnesses on the next panel have some concerns. We are going to continue to look at those concerns and try to make sure the proposal that is finally put forward is the best balance between those competing interests. Let me give you a chance to respond to some of those concerns that have been raised. For example, Professor Bloch, in our next panel, suggests in his testimony that you have given no explanation for why you propose the steps dealing with time limits in the process. Could you explain why you have proposed such time limits?

Ms. BARNHART. Yes. First of all, I think it is really important to look at the entire process, and I do appreciate that all of the Members who spoke before the hearing, at the start of the hearing, commented on the entire process itself and to take everything in a context. The idea was to set expectations for timely consideration and to ensure that at each step of the process the individual who was doing the review was looking at the most complete record possible. Time requirements for submission of evidence would assure that a judge is looking at a better developed record when they look at it, and also that they are better prepared to make a decision

based on the entire record at the time of the hearing. At the same time, the NPRM left the judge discretion to make exceptions and to entertain any evidence that is brought forward at the hearing. We thought that was important, saying we have a time limit but at the same time not trying to take away discretion from the judge. One of the other issues, quite frankly, is the underlying goal of this entire effort has been to make the right decision as early in the process as possible, which speaks to both the timeliness factor as well as to the quality and the accuracy of the decision.

One of the problems that we have right now is rescheduling and postponement of hearings, which affects not only the individual who actually chooses to postpone or delay the hearing, but also the individual who could have had that slot, that hearing slot and didn't get to because it was scheduled for someone else who ends up not using it. It is very important to make sure—and not having evidence and reasons such as that are a big reason for the rescheduling of hearings. Somewhere around 31 percent of our hearings actually end up being postponed. I think the numbers—don't hold me to this—but it is something like 600,000—I can give you precise numbers for the record—are scheduled this past year, but 189,000 were actually postponed or rescheduled. Obviously, that is not helpful to others who are waiting to get a hearing date and move ahead.

Chairman MCCRERY. When you referred to a judge being able to make exceptions, what judge were you speaking of?

Ms. BARNHART. Excuse me, sir. Thank you for reminding me to clarify. The administrative law judge (ALJ), who continues to hold the de novo hearing.

Chairman MCCRERY. There are provisions in your proposal to administratively waive these time limits for, say, presentation of evidence short of going to Federal Court and getting that issue resolved?

Ms. BARNHART. Absolutely. In terms of the 20-day time limit the judge can, for good-cause reasons under his or her discretion, allow the evidence in. The same thing is true in terms of closing of the record and the 10-day requirement for submitting new evidence after the ALJ decision or when it goes to the Decision Review Board. Yes, we did provide for good cause exceptions.

Chairman MCCRERY. Mr. Sutton also recommends some changes in this area, very specific recommendations, so I assume you will look at those and consider those.

Ms. BARNHART. Absolutely, as I said. I appreciate every opportunity I get to say this, Mr. Chairman, it is—we did as long a review and comment process as we could with 90 days. We are interested in getting all the comments from the interested individuals, and certainly, I will consider very carefully the recommendations that are made.

Chairman MCCRERY. One last area I want you to cover before I turn to my colleagues. You proposed to eliminate the third and last appeals step, the Appeals Council. Why do you think that should be eliminated? Why do you think that step should be eliminated to claimants?

Ms. BARNHART. Well, when you look at what happens right now with the Appeals Council, Mr. Chairman, what you have is a situation where people wait and—although I am pleased to say that we have speeded up the consideration by the Appeals Council. When I came into the Agency it was 447 days. It is now 248. We have made some progress there in terms of getting cases through the Appeals Council.

The fact remains that only 2 percent of the cases are actually changed, the decisions are changed after waiting that length of time. It used to be over a year, and now it is approaching a year. About 25 percent of those are remanded. One of the things that I think is really important as we look at the process laid out in the new approach, is not to simply take the outcomes that we see at each level now, each level of consideration now, and apply those to the new approach. The idea is because we have included provisions to improve the quality of the record, beefed up accountability at every step, and in terms of the field office not being able to send the case to the DDS until all the fields are filled out on the electronic form. When the DDS sends it forward to the RO, the RO can remand it to the DDS if they feel it is an incomplete record; same thing ALJ to the RO.

The point is we have put at every stage steps that allow for greater accountability, better documentation and development of the record, which we think actually means that we will end up with far fewer people going all the way through the process. The other thing I would point out is that when you look at the proposal in terms of the cost of the proposal as estimated by our actuaries, essentially they came out to close to a negligible cost, and it really wasn't an increase in costs. It is simply because benefits would be paid sooner, because instead of waiting all the way to the end to get a right decision, based on the changes that we have made, the individual would get the payment sooner in the process, so there are no increased costs except those attributed to paying benefits sooner, which I think lays the groundwork for the fact that we should have less people ultimately going to the final stage.

When they do, our final stage we think is a meaningful one because the Decision Review Board would have the ability to review cases of represented as well as unrepresented claimants. They would be able to review denials as well as allowances. The other thing I want to point out is, recognizing this is without question I think the area the Chairman has really hit on, probably the areas of greatest debate and discussion during the outreach period, quite frankly, when we were talking to individuals and groups, was this whole elimination of the Appeals Council. Based on the concerns and the discussion that we had, what you will notice in the NPRM, we have provided for a phased-in rollout. In fact it is our intent that we would start in one of our smallest regions first, that we would review 100 percent of the cases coming out of the ALJs before making them final, and it is specifically to allow us to do the kind of analysis and monitoring that we feel is important to ensure that we are getting the outcomes that we are expecting as opposed to unintended consequences.

Chairman MCCREY. Will this phase in take a long enough period of time so that after, say, Phase I, if you discover problems,

you will be able to come back and adjust the program, thereby kind of satisfying one of Judge McKibben's suggestions for a pilot program? It sounds to me like your phase in is tantamount to conducting a pilot program before implementing it nationwide.

Ms. BARNHART. Yes, sir, we are phasing it in very gradually. In fact, I would anticipate that we would do one region probably the spring of next year, because my intent would be to hopefully have final regulations published by January or so of this year. I am not a believer in regulations becoming effective the moment that they hit the street, so to speak, so I would like to allow some time for the effective date, and then probably start in a region in April or so of next year if I can, one of our smaller regions. I would envision that region being the only region that would implement this for probably a year. Then we would stand back, take a look at where we are, make adjustments as the Chairman describes, and then move on to maybe one region next, and possibly at the end of the second year, a third region. I actually see a multi-year process in terms of the rollout of the new approach, absolutely. We are not talking about doing one region, and then all of a sudden the next year doing everybody. The model, quite frankly, if you look at what we did with electronic disability in terms of the rollout there and how we made adjustments as we moved along, it wouldn't move as quickly as electronic disability, but it would be that model, just an extended version of that model.

Chairman MCCRERY. Thank you. Mr. Levin?

Mr. LEVIN. Thank you very much. In my opening statement, I mentioned a series of concerns, three of them—the appeal issue, the beneficiary rights issues, and also the evidentiary record issue. Let me start with one of them, and I am going to stick within 5 minutes. I think the Chairman might insist on that anyway. Then others can pick up these other concerns. Let's take the evidentiary issue, the appeal process. The proposed limitation would apply to what would be, what, the third step of the process?

Ms. BARNHART. It would be the third step of the process, the DDS, the RO, and then the ALJ, yes.

Mr. LEVIN. Now, what percentage of the cases more or less goes to the ALJ?

Ms. BARNHART. If I could describe it a little differently than that, I have some numbers I think may make it clear. If you look at initial claims and you take a hundred cases, Mr. Levin, the number that go to the second level, which is reconsideration, is 22. Twenty-two out of the 63 that are denied at the first level move on to the DDS level. Of those 22, 19 move on to the ALJ level of appeal.

Mr. LEVIN. Of the hundred cases—

Ms. BARNHART. Sixty-three are denied at the first step by the DDS, 37 allowed. Of those 63, 22 of those appeal for reconsideration. Of those 22, three are allowed, 19 are denied. Nineteen appeal—virtually all appeal to the next stage.

Mr. LEVIN. Now, in what percentage more or less of these cases is there an attorney, do you know?

Ms. BARNHART. In terms of representation?

Mr. LEVIN. It doesn't have to be an attorney.

Ms. BARNHART. Representation in general for—I can give it to you by Title 2 as well as SSI. In Title 2 it is 74 percent are represented. The vast majority of those are attorneys, I would point out. I don't have that breakout for you, but I can get that for the record. For SSI, 47 percent are represented.

[The information was not received at time of printing.]

Mr. LEVIN. Now, is there any evidence now of a problem with submittal of evidence? You are changing the rule. You are proposing to change the rule, and what evidence is there that it is now a problem?

Ms. BARNHART. Well, it is not a matter of what—I cannot categorize the evidence for you, Mr. Levin, but I do know that based on the number of postponements and rescheduling of hearings that are requested, a number of them the request is made because of things other than a no-show, for example, by the claimant. I think the issue here was really to try to ensure that when the ALJ at the hearing was considering the case, that they had all the information so they would make a good decision, quite frankly, as opposed to just being hit with things at the hearing, that they would have it in advance, that they would be able to make a good consideration, and know what questions to ask and be able to pursue the case properly.

I think one of the things that it is important to keep in mind is this: There were many who recommended that we have an adversarial process. On its face I rejected that because I don't think that is appropriate. I dare say most Members, if not all, of these Committees would say the same thing, because our job is to make sure the people who are entitled to benefits, according to the law as passed by Congress, actually get those benefits, not to make sure that we are presenting the best case we possibly can for our position. I rejected the notion of having an adversarial process, and the time limit that is prescribed in the NPRM really, it is done with the intent of trying to make sure that we have all the evidence at the ALJ hearing so that the ALJ can consider the record to the fullest extent. Obviously—

Mr. LEVIN. Let me just ask you, a 20-day limit, the requirement is different than having all the evidence before the ALJ. If it comes in 10 days or 5 days before—

Ms. BARNHART. Let me say, Mr. Levin, if I may, that 20 days is what we put forth in the NPRM. I am very interested in hearing the comments of others who have alternatives to suggest. I would certainly consider those very carefully. The intent behind the 20 days, which is one of the reasons I appreciate this hearing being held today, is to express—be able to explain intent, and it was actually to make sure that all the evidence to the extent possible is made available to the judge for thorough consideration.

Mr. LEVIN. Others will bring it up. Just very quickly, you consulted widely. Did you talk with groups of employees within SSA about—did you draw on their experience?

Ms. BARNHART. We did. We had meetings with DDS examiners. We had meetings with claim reps. We had meetings and talked to our union representatives. There were a number of different meetings.

Mr. LEVIN. Thank you. Thank you, Mr. Chairman.

Chairman MCCRERY. Mr. Herger?

Chairman HERGER. Commissioner Barnhart, first I would like to thank you and your staff for all your hard work, thoughtfulness, and persistence in developing the proposed rule we are discussing today. In addition, the many organizations and groups who met with you, discussed the proposed rule with Committee staff, and submitted written comments are to be commended for their contributions to the process. Now to my questions. One, could you please give us additional information about how implementation of the proposed rule will help ensure the accuracy and consistency of decisions in the disability determination process? Do you expect to see a reduction in fraudulent claims and overpayments due to these changes?

Number two, I am particularly interested in your work opportunity initiative. Could you please explain how your initiatives differ from previous return-to-work projects, when you expect to evaluate your initiatives, and what results have been achieved so far? Do you think an improved disability determination process will affect work rates in the SSA's disability programs?

Ms. BARNHART. Mr. Chairman, I will do my best to respond to all those in less than 5 minutes. If I run up against it, I promise you I will submit answers, elaborations for the record. I want to say first of all, with respect to accuracy, the NPRM contemplates an entire revision of our quality control process to create an inline quality assurance component as well as a centralized as opposed to regional quality control mechanism, which obviously I know you are very familiar with the preaffectuation reviews that are conducted. I believe having a centralized unit where we can actually direct that from one place in terms of those preaffectuation reviews being conducted and so forth will do a lot for improving consistency and, therefore, ensuring that the people who should be getting the benefits and are entitled are getting them and those who aren't do not.

The same would be true in terms of overpayments and fraud. I do believe that we would be in a situation by improving the decisionmaking all along, we would have a much higher confidence level, quite frankly, in the accuracy of our decision because we have a better developed record, we have accountability at every step. Ultimately that should reduce overpayments, quite frankly, Mr. Chairman. I would anticipate taking whatever concepts that we can in terms of the quality and the accountability and applying those to the Continuing Disability Review (CDR) process as well so that we can ensure the same kind of high-quality decisions made in our CDR process as in the initial determination.

With respect to the work opportunity initiative, I assume you are talking about the demonstration projects that are included as part of the new approach, and we are very pleased with those. We think we touch on some very important concepts that can be instructive for these Committees as you look ahead to the direction the disability program might and ought to go or could go in the future. We believe that, for example, what we are doing related to the accelerated benefits demonstration, which would allow individuals to—essentially it would waive the 24-month requirement and allow people to get health benefits immediately if there is a great likeli-

hood that their health condition could improve if they received benefits right away. I know that that is something that Members of these Committees had asked me about in the past in either individual meetings when we have sat down, sometimes at hearings. I believe we have a Member who has actually introduced legislation looking at that whole 24-month waiting period, and so we would hope that we would have some good information that could guide the Committee and be helpful in your work in the future.

Chairman HERGER. Thank you.

Chairman MCCRERY. Dr. McDermott?

Mr. MCDERMOTT. Thank you, Mr. Chairman. As I was reading the testimony of some of the people who will follow you, I had a similar feeling to some of their comments that the people who will do well in the system are those people who have a lawyer. Absent a lawyer, I tend to think these people are going to fall by the wayside one way or another and be denied over and over again, partly because they cannot get their act together. Part of disability is that maybe your act is not together in the first place. The question then is: Is it your intent to make this basically a legal procedure or an administrative procedure by which people will receive their benefits? It goes to the question ultimately of why is this a better system than what we have now. What have you done in it that really makes it better for the disabled to come and present their case?

Ms. BARNHART. Thank you for that question, Mr. McDermott. I think we have done a number of things that make it better for the person with disabilities and claimants to present their case. One is that the new process is more transparent than the current process. You have spoken to the complexity of the new approach. Well, the current process is certainly not an uncomplex process itself. We require that the DDSs provide a better explanation of their decision. The ROs have to provide a better explanation of their decision, which will be made available to the claimant, which obviously assists them as they make the decision to move on to the next step or not.

Mr. MCDERMOTT. In the present system, it is just a simple denial?

Ms. BARNHART. That is right, basically, or pretty much boilerplate, not—

Mr. MCDERMOTT. This time you have to write down—

Ms. BARNHART. You have to explain—

Mr. MCDERMOTT. —what the basis is for your decision.

Ms. BARNHART. Correct. Correct, and I think that will help, makes it more transparent. One of the complaints that we heard repeatedly from claimant organizations and claimants themselves is that the DDS reconsideration level of review, nothing against our DDSs, but it ends up being a rubber stamp because they are reviewing themselves, quite frankly. I think that is not unexpected, and that is why 85 percent of the cases remain the same decision they were when they went through the initial consideration.

Having a Federal review, a centralized Federal review that does not allow for variation from State to State or DDS to DDS, has been a concern of this Committee and the Finance Committee, obviously, for many years. I think by having the right set of medical eyes looking at the evidence—and this, if I may say—I have told

the Committee this before. I don't get a lot of phone calls at home, but I do get phone calls at home from disability claimants. I am one of those old-fashioned people who thinks if you are going to serve the public, then your name should be in the phone book, and mine is. Usually when I get them, I get them late at night, and I do want to say that all the individuals whoever called me have been extremely polite and thoughtful and apologize profusely for interrupting me at home saying they know I have a family, too.

When they call me, it is almost in desperation, saying, "You don't understand. Here is what happened. I have this extremely unusual condition or disease, and the doctor who looked at it and made the decision has no background in this particular"—and you know how there is increasing specialization in the medical profession. They have made the case, saying, "Please, please, all I ask is just have a doctor who has experience with this kind of case take a look at the evidence and see what their insight says as opposed to someone who doesn't have that." I actually think we have done a number of things to try to improve the process for the claimant. With regard to the issues in terms of—I guess I would call them more procedural kinds of things that the Committee is choosing to focus on, and rightfully so because people do not talk about the things they are happy with. They talk about the things that they are concerned with. Again, I just want to re-emphasize that I welcome comments. I will consider them very carefully.

Mr. MCDERMOTT. Can I go to just one other issue that my own experience tells me I want to think about? When you have gotten a panel together, panels tend to have a certain mind-set, or you get on a panel because you have a certain mind-set. I have watched lots of industrial injury cases. I did lots and lots of those in my practice, and the whole question of the attitudes of the people, are we a giver of benefits or are we a denier of benefits? You have now got this panel, and those are the ones you are going to face, and it is going to be the panel in the 3rd District or the one in Seattle or whatever. Who chooses them? How are they reviewed? What is the process by which you choose these experts that become the panel?

Ms. BARNHART. You mean in terms of the Federal Expert Unit (FEU)?

Mr. MCDERMOTT. Yes.

Ms. BARNHART. Well, we have actually asked the Institute of Medicine to make recommendations to us about the standards that should be required for physicians who would make judgments on various cases, and I am meeting with them in October. They are going to provide a report to us in November, and I would hope to have standards published within 6 months of the effective date of the regulation. I am not sure that I am answering your question, sir. Is that what you were interested in?

Mr. MCDERMOTT. Yes, giving me the direction to think about how you are going to put those panels together, at least what pieces of paper they have to have on the wall to be qualified to sit on the panel. That gives me at least a start.

Ms. BARNHART. The idea is that the—

Mr. MCDERMOTT. The Institute of Medicine is the one that you think will make those decisions.

Ms. BARNHART. Well, they are actually going to make recommendations to me, and then I will issue standards. We felt it was important to go obviously to a respected entity asking for guidance on that as opposed to simply just—and physicians, as opposed to having non-physicians making those determinations, because we really are seriously committed to making sure that we improve the quality of the medical review that is taking place.

Mr. MCDERMOTT. I guess the question always comes: Is the job of the panel to save money for the system or is it—whatever it is.

Ms. BARNHART. Let me say—let me say, cost has not been the driving factor. Saving money has never been one of the goals. I can honestly tell you, all discussions, the goal has been—and as I said, if you look at the estimate that our actuary did, it actually shows that increases cost around \$1.2 billion over 10 years, I believe, an average of \$120 million a year, which is considered negligible in a program with a \$550 billion budget when you look at all of Social Security. The goal was to make the right decision as early in the process as possible. That really has been the driving goal here.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman MCCRERY. Thank you, Dr. McDermott. Mr. Beauprez?

Mr. BEAUPREZ. Thank you, Mr. Chairman. Madam Administrator, it is good to have you in front of us today. I think you just answered one of my questions. Simply put, I guess the objective of all of this is to get the right answer as quickly as possible, pay the benefits as appropriate, and if for some reason the claimant feels aggrieved, get a decision on that as well, as quickly and as accurately as possible.

Ms. BARNHART. That is correct.

Mr. BEAUPREZ. Let me pursue that, then, for just a little bit, and only to play devil's advocate, because, frankly, I think I on balance agree with the objective. The whole consideration of a staged rollout or pilot project working with a smaller region—and I think you said that you would anticipate perhaps final rulemaking around the 1st of the year, a rollout of an initial project sometime later into 2006, spring perhaps, and then maybe that would be—that first phase would be a year-long or so process, and then step by step from there on. Again, on balance, I think I agree and accept the premise, but that seems like for the number of people that we have out there, still kind of the multitudes that could utilize a new and improved process, is there a way to reach that same objective but perhaps get there even quicker?

Ms. BARNHART. Well, one of the things that we have invited comments on specifically in the NPRM is the idea of the timing of implementing the quick decision units. We contemplated going from one place to another, but we recognize, as you are pointing out, Mr. Beauprez, that there are some aspects of the NPRM that might actually lend themselves to moving ahead sooner across the board. Quick Determination Decisions is one of the things that comes to mind. We have specifically invited comments on those kinds of things, and I am hopeful that we will receive some recommendations and ideas about what others believe would lend themselves to quicker implementation.

Mr. BEAUPREZ. Well, I am very concerned about that whole issue of unintended consequences, so I am sensitive to that and would, I guess, again, on balance, encourage you to go forward with some caution. At the same time, people that are applying for these kind of benefits have a rather critical need. Time and accuracy is obviously critically important if you happen to be that individual.

Ms. BARNHART. I could not agree with you more. In fact, other Members of the Committee who were here a few years ago when I first testified—I guess it is almost 4 years ago when I was first in this job—are familiar with the 1,153 days that I talked about it taking in the best worst case. If you go through every level of appeal and you got optimum numbers based on what we were producing at the time, it would have taken 1,153 days. Right now, last year we had improved that by about 104 days. It is not—one of the points I do want to make is it is not like we are sitting and doing nothing even in the current system. I anticipate that now, based on where we are with electronic disability, the fact that we have 49 out of 50 States, 54 DDSs, because we have many territories involved already, and New York is the remaining State to come up under electronic disability and is scheduled for January of 2006, we will be seeing that number improve, what is now a thousand whatever, improve even in the intervening years as the new approach rolls out because the 100 days that we have spent looking for files on average, we won't be spending; the 60 days that we spent on average mailing files back and forth from one location to another, we won't be spending.

Believe me, we have implemented centralized screening. We have done a number of things, and we constantly come up with other ideas. I said from the very beginning, when I first spoke to people inside the agency, it is not going to be one single thing—there is no one single thing, even this one approach, this one new approach, that is going to fix the disability process and help us provide better service. It is going to be the combination of some very big things like the new approach, but also a number of smaller things that we have done and continue to do. Please understand, we are not waiting for this to happen and doing nothing in between. I would be delighted to submit for the record all the activities that we have undertaken to improve the timeliness and the process.

[The information was not received at time of printing.]

Mr. BEAUPREZ. Well, I applaud the effort and certainly look forward to your progress. I yield back, Mr. Chairman. I see my time is about to expire.

Chairman MCCRERY. Thank you, Mr. Beauprez. Mrs. Tubbs Jones?

Mrs. TUBBS JONES. Mr. Chairman, thank you. Madam Commissioner, so happy to have you here once again, and I invite you back to Cleveland anytime. I just want you to think about—and in my background, I was a municipal court judge where I used to do traffic cases, and we tried to do 85 or 100 in a morning. Then we would do small claims cases. Then in the general jurisdiction court that I was in, we would have unbelievable dockets doing cases. Clearly, the people who were represented by counsel managed the process a lot better than the ones who were not. If, in fact, you decide to implement the changes that you have, not only should you

say that it is within the discretion of the administrative judge to extend the timelines, it should be part of their training that where someone is unrepresented, they are required to give them the benefit of the doubt. You can say to someone, okay, you have the discretion, but when they are looking at 200 cases on their docket, the discretion kind of leaves. Okay, flop that one out and move on to the next one.

I am not being accusatory of administrative judges. I know they have a lot of work and they do a decent job. I know a whole bunch of them back in my area. It should be part and parcel, if you are going to implement these new changes, that there specifically be something that says to them that in this instance you should favor giving an unrepresented person an opportunity for an extension. I was just telling my staffer that seeing how we have a little time left, I may even host a hearing in Cleveland to allow my disability people, before the deadline, to come forward and give me any ideas or suggestions that they might have. For purposes of today's hearing I want to focus on a particular area. In 1999, SSA identified approximately 130,000 SSI recipients who appeared to be insured for Title II disability insurance benefits based on their own earnings, but were not receiving Title II benefits. Through 2004, additional cases have been added to this list. Some of these beneficiaries have entitlements dating back as far as 1973. The SSA has identified these cases and put them in a special case file called Special Disability Workload (SDW). What is the net effect of this on the SSI recipient, and do they remain eligible for SSI? Secondly, is there some sort of windfall offset? If so, what does that mean in dollars and cents to the recipient?

Ms. BARNHART. Okay. You have asked several questions. First of all, yes, you are speaking about what we call the SDW?

Mrs. TUBBS JONES. Yes.

Ms. BARNHART. In every case, they do not necessarily remain eligible for SSI because it depends on the amount of Title II benefits that they are receiving. There are some issues—and, in fact, there are some individuals who are concerned about that because as they make the move, although they may be getting more money and moving to Title 2 benefits and getting Medicare, they no longer get Medicaid. This has been a concern that has been expressed to me, but it happens to be the way that the programs operate. As far as your first question, not necessarily. They do not necessarily maintain their SSI eligibility. I am sorry. I apologize. What was your second question?

Mrs. TUBBS JONES. Is there some sort of windfall offset? If so, what does that mean in dollars and cents to a recipient? In other words, with a different determination.

Ms. BARNHART. It actually depends. It depends on the circumstances. We have identified people who we believe could be eligible, and we are working our way through those. My understanding is that the so-called windfall ranges significantly. In some cases, it is thousands of dollars. There is no question about it.

Mrs. TUBBS JONES. I am not expecting that I am going to get all of these answers right here. If you could have someone follow up with me, I would appreciate it.

Ms. BARNHART. I would be happy to. I could submit it all for the record, all the information that we have.

[The information was not received at time of printing.]

Mrs. TUBBS JONES. Secondly, do these new regulations apply to those SDW cases? I used to work for Equal Employment Opportunity Commission, and so we used to "rocket the docket." That was the expression that we used in some cases, and they would be set aside and be dealt with differently, and new regulations would not apply. Are the new regulations going to apply to these SDW cases?

Ms. BARNHART. I am glad you asked that question. The new regulations apply only to people who apply for disability after the regulation comes into effect in a particular region. Not only do they not apply to those who are currently in the SDW group that we are looking at, but they do not apply to anyone who has already applied for disability. It would continue to apply after the time it rolls out in a region.

Mrs. TUBBS JONES. Okay. Apparently, these SDW cases were first addressed in 2001. They were suspended in November 2001, resumed in 2002, and they are divided by SSA region. Your guidelines state that SDW cases are priority cases and will not be backlogged or staged. Do you know how many—can you have somebody let me know how many cases of these type of cases remain unresolved?

Ms. BARNHART. Yes, I can absolutely do that.

[The information is pending.]

Mrs. TUBBS JONES. Okay. Of the 260,000 cases that have been identified nationwide, 45,000 are in Region 5, which includes Ohio. It appears that you have been doing a pretty good job of having completed 27 percent of them so far.

Ms. BARNHART. We actually had a plan to have them all completed by 2007, if I could just interject here.

Mrs. TUBBS JONES. Sure, please.

Ms. BARNHART. I know many Members on these Subcommittees have supported our budget request over the years. We did not get all the money we requested in the budget, and so for that reason, we weren't able to work the cases down as quickly as we would have liked. We actually have cadres of individuals doing them all over the country, and we have set goals for every year to try to finish this workload as quickly as we can. I must say, in all candor, at this point our plan has us completing work on the cases in 2010.

Mrs. TUBBS JONES. What I would ask again, as I talked about in the earlier part of my questioning—I am sorry, Mr. Chairman. I did not read the clock. I promise I will be done with this. I did not watch the clock. I would hope that, again, when you start talking about processing specialized cases and the need to resolve them that your people would keep in mind the people who are unrepresented, and even though they are anxious to get a resolution, most of them would prefer that it take a little longer time than to get a determination that they are not eligible.

Ms. BARNHART. Let me just say I appreciate your comments about the unrepresented individuals who come before us, and I do think that one of the pieces of legislation that this Committee sup-

ported in the Social Security Protection Action (P.L. 108–203) was to allow attorney fees to be deducted for SSI claimants in the same way that they are for Title II. That is a relatively new provision. I would fully expect that as that provision plays out, we would see representation of people who are applying for SSI benefits to increase over time. The other thing I want to say is this: I am very sensitive to the whole notion that the outcome is generally more favorable if you are represented as opposed to if you are not represented. One of the things that we would be looking at at each step of the quality review that we would do would be unrepresented cases specifically, which I believe would allow us to see the effects of the new approach and take whatever remedial action was necessary to improve the situation.

Mrs. TUBBS JONES. Thank you. Mr. Chairman, thanks for your indulgence.

Chairman MCCRERY. You are quite welcome. Mr. Pomeroy?

Mr. POMEROY. Thank you, Mr. Chairman. Madam Commissioner, I admire your managerial competence and focus, trying to get things running right, and to the extent that efficiency might at least give rise to a conversation about making certain that rights are fully protected and opportunities fully preserved. This kind of dialogue is an important part of the process. I wish we had you cloned and another part of you over at the Federal Emergency Management Agency and Homeland Security.

[Laughter.]

As we look at the whole Hurricane Katrina aftermath, are there things you have learned about redundancies in records and such that ought to be implemented systemwide to make certain that we don't have some catastrophic loss of records in a natural catastrophe or a terrorist catastrophe?

Ms. BARNHART. I am so glad you asked that question, Mr. Pomeroy, because one of the things we learned is that we saw the value of electronic disability, immediately. If I could give you just an example: As you know, the paper disability cases, as we have discussed, that I visited in for the last year—

Mr. POMEROY. Right.

Ms. BARNHART. —are sometimes 8, 12 inches tall. In Mississippi, because in the Louisiana DDS, we actually had over 5,500 disability cases pending at the time that Hurricane Katrina hit. We were able to access over 1,900 electronic disability cases immediately, and to assign them right away, because, as I am sure you can appreciate, we were not allowed to enter the DDS, which was in the flooded area for several days to go in and actually get the paper cases out. We did eventually, I am happy to say, retrieve all the paper cases, but it was days later, and there certainly was every possibility we might not have been able to in another circumstance.

Mr. POMEROY. You have system backup? You have the electronic files—

Ms. BARNHART. Yes.

Mr. POMEROY. —aren't just on site?

Ms. BARNHART. Yes.

Mr. POMEROY. They are somewhere else?

Ms. BARNHART. Yes. They are, and the other thing that is important, and I am delighted to have the opportunity to point out, is that we are proceeding very carefully as we roll electronic disability out before we convert to absolutely relying on the electronic case itself. We maintain a paper folder and an electronic folder for the first several months, and we have a validation process that we go through, where we look at the paper folder. We look at the electronic folder to make sure that everything that should be in the electronic folder from the paper folder is in there. So far, we have had six States pass the validation—we have only done it in six States. As I say, we are moving in a measured way. South Carolina just yesterday was certified in what we call IDA, which stands for Independence Day. When the staff told me they had named it IDA, I thought it was for Ida Mae Fuller, our first Social Security beneficiary, but it was actually for Independence Day. We will have six more States before the end of FY 2006.

Mr. POMEROY. Now, this whole move to the electronic format is not really pioneering. Essentially, you are replicating now in these vast SSA claim settlement procedures which have long been totally electronic in private sector claims adjudication as part of this; is that right?

Ms. BARNHART. That is right. That is right. I do feel compelled to say, though, that because of the nature of the work we do in disability and the amount of medical evidence that we collect in every case, when electronic disability is fully implemented, we will have the largest repository of medical records in the entire world.

Mr. POMEROY. I didn't mean to suggest that it is not a very important initiative. I just mean this isn't experimentation?

Ms. BARNHART. Oh, no. Oh, no. I should say electronic medical records. No, we didn't feel it was experimentation on—I am sure what you are alluding to, and I appreciate it, is the fact that there were some who thought that perhaps we shouldn't have moved ahead as quickly as we did. I think what has been proven is that actually we have done so in a very measured way. We have made adjustments as we needed to. We weren't plowing entirely new fields. No, if that is what you are asking—

Mr. POMEROY. Right. Right. I do want to ask you about the ALJ list and how that is coming, because I view that as something that is very important for this Committee to ask you. We understand that that is out of your control. That is in the Office of Management and Budget, I guess.

Ms. BARNHART. Personnel Management.

Mr. POMEROY. Personnel Management. Can you tell me when was the last time the list of eligible ALJ personnel, personnel that might be eligible for consideration for hiring as ALJs. When was the last time that list was open?

Ms. BARNHART. I may be wrong within a year or 2, but I believe it was almost 10 years ago, Mr. Pomeroy.

Mr. POMEROY. Anyone within the last 10 years that might graduate from law school or from their practice develop a particular expertise that they want to apply in an adjudicatory role, they haven't been able to even have been considered?

Ms. BARNHART. That is my understanding.

Mr. POMEROY. Yes. Now, how many ALJ positions are open? I know headway has been made at bringing more on.

Ms. BARNHART. We hired 100 last year. We hired 100 this year, and again I want to thank this Committee because without the work of the Members of this Committee, I frankly wouldn't have been able—

Mr. POMEROY. How many short? I am sorry. It is just my time is running out.

Ms. BARNHART. We are about—we think that we are about 100 to 150 short still. That is only because we continue to lose. For every 100 we hire in a year, we lose another 30 or so. We net about 70 when we hire 100 that we keep over time.

Mr. POMEROY. Are you aware of any rationale whatsoever that would freeze opening of that list?

Ms. BARNHART. Well, my understanding is that based on the lawsuit that took place, the Azdel litigation, that the Office of Personnel Management now has to recast the entire test and the factors for eligibility. They have not developed a test yet, and then once they develop the test, they have to test it, pre-test it—

Mr. POMEROY. Yes. When was that ruling decided—and this is my final question.

Ms. BARNHART. Over 2 years ago, Mr. Pomeroy.

Mr. POMEROY. They have had some time to do all this. Mr. Chairman, I would think the Committee may want to inquire in terms of how the Office of Personnel Management is coming at the creation of criteria to get a new list established. I think a legislative prod to this group would be most helpful. Thank you, and I yield back.

Ms. BARNHART. Thank you. I appreciate that.

Chairman MCCRERY. Thank you, Mr. Pomeroy. Mr. Neal?

Mr. NEAL. Thank you, Mr. Chairman. Like the other members of the panel, Ms. Barnhart, we want to congratulate you for the focus you have brought to this task. Certainly, moving the electronic files should prove to be a tremendous help in the overall goal of what we are trying to accomplish. Do you think it might make some sense to slow down the implementation of this regulation just long enough to assess whether or not electronic filing can address the problem on its own?

Ms. BARNHART. I actually think that—and I said from the very beginning—that improving the disability process would require a successful implementation of electronic disability, because there are many things in this new approach that I wouldn't be able to do absent electronic disability. I wouldn't be able to have, for example, a centralized quality control unit. I wouldn't be able to have centralized reviewing officials that could be supervised in one place, getting one direction from one leader, and so on, which I think are really critical to improving the accuracy of the decisions all the way through the process. I don't believe—I believe there are gains we can make from electronic disability in and of its own right. I think there are ways we build on electronic disability in this new approach. I don't believe that there is anything that would prohibit us from moving ahead in the same prudent and deliberate manner that we moved ahead with the electronic disability process, quite frankly.

Mr. NEAL. Would there be some trade-offs for the claimants as we proceed in this direction?

Ms. BARNHART. Some trade-offs in terms of—I am sorry. I am not—

Mr. NEAL. Would there be some trade-offs to the claimants as we move to electronic filing?

Ms. BARNHART. Oh, trade-offs for the claimants?

Mr. NEAL. Yes.

Ms. BARNHART. I think the claimants are already seeing the benefits. I really see benefits accruing to claimants through the electronic filing.

Mr. NEAL. No downside?

Ms. BARNHART. I don't see downsides. That doesn't mean that something can't pop up. We certainly haven't identified any, because frankly, it allows us to track their case better; as I say, not to have delays because we can't manage where the case is or the mailing issue. It allows us to make sure that when the initial interview is done with the claimant in the field office, we get as much information as we possibly can, and that we need to so when it gets to the DDS, they are not spending all this extra time going back and trying to get information that should have been gotten at the prior stage. I really don't see downsides, I would be interested in hearing them, because I am not aware of them.

Mr. NEAL. New England would be a great place for you to start next spring, if you wanted to find a test case. It is very compact, and you can travel across it quite easily.

Ms. BARNHART. I am well aware of that, Mr. Neal.

Mr. NEAL. Okay.

Ms. BARNHART. Yes. I appreciate that, and we have a great regional commissioner up there, too, Manny Boz. I am sure you know him. Thank you.

Chairman MCCRERY. Thank you, Mr. Neal. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. Commissioner Barnhart, it is a pleasure to see you again and just right off the bat, kudos for the steadfast effort to just move us forward. I think if nothing else, we have to applaud you for just keeping it going. I remember a few years back, we were talking. We all had ideas, but you have been good enough to at least put them in writing. I know that some of us have some concerns, but I think it is very important to say to you thank you very much for moving the ball. There is a lot of dust that gets kicked up, but certainly the ball is further down on the yardage line than it was before. Thank you very much for that.

Ms. BARNHART. I appreciate that.

Mr. BECERRA. I want to make sure I acknowledge the Chairmen of the Committees as well and also Representative Shaw, who was previously the Chairman of the Subcommittee on Social Security, because they, too, have been diligent in just moving this forward, and I want to thank the Chairman for this. I think we are making progress. I will tell you this, because most of the comments have been made, and I think you have made a good faith effort in trying to respond. This is a concern I see with some of the regs as I read them. Rather than move toward a system which has always been based on truth seeking, informality, a non-adversarial process

and making it better, for the most part, individuals who aren't that well heeled, and, in many cases, are in desperate need of some assistance through these programs, that we might formalize a process too much. If the greatest success we see from these new regs—and, by the way, I am about to say something about attorneys, and I am one, so nothing against attorneys—but if the greatest success we see is a dramatic increase in the hiring and retention of attorneys to handle these adjudications, then I don't know if we have succeeded, because we have just made it much more difficult for those individuals who are seeking these benefits to actually exist, because there goes a good chunk of their money.

Now, in many cases, an attorney will be needed because cases can get complicated. To me, the issue here is too often we had an adjudication process where there was inadequate evidence. Evidence got left out. The claimant didn't prepare a good case. Evidence came out later than the hearing, or during the process it came out a little late. Maybe it was the claimant's fault. Whether or not it was the claimant's fault, it was always my sense that we tried, from the government's perspective, to run this system saying, claimant we are going to give you every opportunity to prove that you are entitled to these benefits. If you can't prove it, you are going to be denied, but our conscience will be clear that we gave you every chance to do so because it is going to be a truth seeking process that is informal. We will not be your adversary in it. My concern—and I say this with some cautionary note, and, again, recognizing that I mostly appreciate what you've done, because you moved the ball forward, as I said—I don't want to see it turned into an adversarial process, where it is similar to a court process.

Ms. BARNHART. Let me just say I don't, either. It was not my intent, as I said. There were those who recommended repeatedly that we needed to move to an adversarial process. I felt that was absolutely a supposition, a suggestion, that should be rejected on its face, because I, too, agree that our job at SSA is to make sure people who are entitled to benefits get the benefits that they are entitled to.

Mr. BECERRA. I think 150 percent that you are telling me what you personally feel. For example, let me give you a concern I have: Why close the record so quickly, 20 days before the hearing, on someone who is probably having difficulty co-existing? I know there are opportunities to still do more during the adjudication itself, but unless we feel that these folks have retained an attorney and are actually going to be prepared to make sure that 20 days before a hearing, they have done everything they can to get the evidence forward, we may create a stumbling block there.

Ms. BARNHART. Certainly the intent is not to close the record prior to the hearing. There is an intent to close the record after the ALJ decision is rendered. That is an area where I appreciate comments that would help us clarify as we move ahead in this process. As I explained, and I am not sure you were here at the time I explained, we did provide discretion to the judge to accept evidence at the hearing, because the intent was really—

Mr. BECERRA. See, Commissioner, the difficulty I have with that is that now we are sort of—the doors are closing on the claimants; whereas, before we left them open, and if they are so open

that they have no excuse for having failed, then it is not our fault. If we set up these more rigid standards and I think a lot of folks will be legitimately able to claim that they were not versed in the process, and unless they hired an attorney, which they didn't have money to do so, they were not going to be fully prepared. That is the concern I have. I fully appreciate what I think the intent of that regulation is to require the evidence in advance, because too often folks walk in with the evidence the day of the hearing. We don't want that. Absolutely.

Ms. BARNHART. Right. Right. Right.

Mr. BECERRA. I know my time has expired, so, Mr. Chairman, let me just say this: I think where I have the most concern is in not allowing the record to be reopened again and instead calling for a reapplication by the claimant if things fail. I think that is—to me, it is almost a fatal mistake, because you have now made everyone go back to step one, and, see, that to me is not an informal non-adversarial process. To me, what we should be doing is saying if you failed, you failed and it was your fault; and, if it is your fault, don't blame us. We kept the doors open as long as we could. I think that is the way we should always handle this, because we are not talking about someone who is suing someone else because of a land grab. This is not the People's Court where television selects the most juicy cases. These are individuals who are saying, "I am disabled."

Ms. BARNHART. Absolutely.

Mr. BECERRA. Or "I need assistance." We shouldn't force them to sort of play the People's Court. I would just urge you that—and I say this knowing how much work you have done. I just say that as you continue—and I think in very good faith—moving forward some regulations that we just try to keep working and make sure that we have kept this a non-adversarial, as informal, and as much a truth seeking adjudication process as we can versus an adversarial, litigious process.

Ms. BARNHART. If I may just say, your comments are well taken. I appreciate them, and this NPRM obviously was a move from a concept to making something operational and practical. My goal is to make sure we have the best operating and most practical system that we can have. You have my assurance that I will consider it very carefully.

Mr. BECERRA. Thank you. You are making progress, and we commend you for it. Thank you, Commissioner, and thank you, Mr. Chairman.

Chairman MCCRERY. Thank you, Mr. Becerra. Commissioner Barnhart, when you gave the statistic earlier that 74 percent or something like that of applicants were represented, does that number include applicants who come to my office seeking assistance, and I send you a letter—

Ms. BARNHART. No.

Chairman MCCRERY. —asking? No?

Ms. BARNHART. No, sir. That includes—I am glad you asked that question, if I let the impression. No. No. No. Obviously, the cases that are referred through Members of Congress, some of those are represented, and many of them are not obviously.

Chairman MCCRERY. Right. Right. Okay.

Ms. BARNHART. No. No. That 74 percent—I believe the break-out—and I can provide it for the record—is something like around 63 percent are attorneys and about 11 percent are non-attorneys, and, as you know, one of the other provisions this Committee acted on in recent years was the creation of the certification process for the non-attorney representatives, and I am pleased to say we did conduct the first test, and I can give you the numbers on that. The vast majority of people did pass. We actually had it certified and so forth in terms of the test itself by an independent organization. We feel very good about where we are. I would be happy to provide a report for the record on that.

[The information was not received at time of printing.]

Chairman MCCRERY. Thank you. Well, my office, I know, and probably those of most of my colleagues handles an awful lot of applications for disability benefits, and probably the most common complaint we get, in my office anyway, is that the dad garn process just takes so long. Why can't we get a decision sooner? Here I am hanging out here. Yes, if I am finally qualified, I will get back payments and all of that. In the meantime, I am starving to death. I applaud you for recognizing that that is perhaps the biggest thing wrong with the program is the delays in getting an adjudication, delays in getting a final decision. Thank you for methodically going through this process and trying to come up with something that solves that big problem that I think will make the lives of those people who are desperate for help at least a little bit better.

Ms. BARNHART. Thank you so much, Mr. Chairman.

Mr. BECERRA. Mr. Chairman, would you yield? You said something I think was very important, and I hope, Commissioner, you don't misread what I said. I think that much of the delay—and again, I hope the claimants don't misunderstand what I am about to say—a lot of the delay is due to the claimants, like, in some cases, not understanding the process and so forth. I think to the degree that a claimant becomes the responsible party for the delay, these limits are good, because it sets a timeframe. You can't sit on evidence. You can't. If your doctor is not sending something in, at some point, it is your responsibility to make sure the doctor does it. You can't just say the doctor never sent it in. I think the more we are open and say we did nothing on our part to delay this. If you take a look at the record, and the reason it has taken so long is because your doctor never sent this in for 2 months. That is not our fault. I think the more that we set limits based on a clear showing by the claimants if they haven't moved forward, I think that is eminently fair. You struck on something that, again, is what we see in our district office as well in terms of the claims. Thank you, Mr. Chairman.

Chairman MCCRERY. Sure. Thank you.

Ms. BARNHART. I appreciate that.

Chairman MCCRERY. Commissioner Barnhart, thank you very much. Now we are going to move to the second panel, and, for that, I am going to turn the hearing over to my very distinguished colleague, the Chairman of the Subcommittee on Human Resources, Mr. Herger.

Chairman HERGER. Thank you, Chairman McCrery. On this panel we will be hearing from the Honorable Howard D. McKibben,

Chair of the Judicial Conference Committee, Federal-State Jurisdiction, Administrative Office of the U.S. Courts; Mary Ford, Co-Chair of the Social Security Task Force, Consortium for Citizens with Disabilities; the Honorable Dana E. McDonald, Immediate Past Chair of the Social Security Section of the Federal Bar Association; Andrew Marioni, President, National Council of Disability Determination Directors; Thomas Sutton, President of the National Organization of Social Security Claimants' Representatives; and Dr. Frank S. Bloch, Professor of Law at the Vanderbilt University School of Law. Mr. McKibben to testify.

**STATEMENT OF THE HONORABLE HOWARD D. MCKIBBEN,
CHAIR, JUDICIAL CONFERENCE COMMITTEE, FEDERAL-
STATE JURISDICTION, ADMINISTRATIVE OFFICE OF THE U.S.
COURTS**

Judge MCKIBBEN. Thank you, Mr. Chairman and Members of the Subcommittees. My name is Howard McKibben. I am United States District Judge for the District of Nevada, and I currently serve as the Chair of the Judicial Conference Committee on Federal-State Jurisdiction. I am testifying today on behalf of the Judicial Conference regarding certain aspects of the proposed regulations by the SSA to revise the disability claims process. I deeply appreciate the opportunity to be here today and would ask that my written statement, which has been provided, be included in the record.

The Judiciary commends the SSA for its efforts to improve the quality of agency decisionmaking in connection with claims for disability benefits. We also appreciate the open dialogue that Commissioner Barnhart and her staff have fostered with the Federal Judiciary, as they have developed the proposed changes; she has attended several of our Committee meetings and has spoken with us directly on other occasions, and we deeply appreciate that. Our Committee has closely monitored these developments. At its March 2005 session, the Judicial Conference of the United States determined, and I quote, "to support efforts to improve the efficiency and effectiveness of the process by which the SSA considers disability insurance and SSI claims, but oppose the elimination of a claimant's right to request review of an ALJ's adverse decision by the Appeals Counsel or another administrative reviewing unit with comparable authority prior to seeking relief in Federal District Court."

My comments today on behalf of the Judiciary are, thus, limited to the role of Appeals Council and the ability of claimants to seek administrative appellate review. The regulations that have been published call for the gradual elimination of the Appeals Council, as we understand it, and importantly the elimination of the right of a claimant to request administrative review of disability decisions issued by an ALJ. It appears that a Decision Review Board, which has been discussed earlier, would be created that would be authorized to choose certain ALJ decisions for review, including decisions that are both favorable and unfavorable to the claimant. Apparently, the Board would use random sampling, or identify certain types of cases as typically warranting review. However, we do not know how many ALJ decisions the board would select for re-

view or what the precise standards would be for such selection. What we do know is that claimants will no longer be able to ask this new board to review the ALJ's decision except in very limited circumstances. This outcome is contrary to the conference position favoring preservation of the right of a claimant to request review of an adverse ALJ decision by the Appeals Council or another administrative reviewing unit with comparable authority.

The SSA has stated that the Appeals Council adds processing time; that it generally supports the ALJ decision; and that it fails to provide meaningful guidance to ALJs when it disagrees. The Judiciary, however, believes that the proposed acceleration of District Court review of disability claims denials may result in more costs and further delays for claimants because it merely shifts the time for considering such claims from the administrative process to the courts. It could also greatly expand the number of appeals to the Federal Courts.

Based on information provided by SSA, the ability of claimants to request review by the Appeals Council appears to provide a helpful screening function. SSA reports that during Fiscal Year 2004, the Appeals Council reviewed 92,540 requests for review. Information previously received from SSA suggested that 2 percent, approximately 2 percent of the claims are allowed outright by the Appeals Council; 25 percent, which is a significant number are remanded to an ALJ, which often results in allowance to claimants. I don't have the precise figures, but I believe it is somewhere in the neighborhood of 60 percent are then allowed once they have been remanded. That may include the ones from the District Courts, too. Thus, the right to request administrative appellate review also appears to result in an award of benefits to a significant number of claimants without the need for further review by the Federal Courts. The Administrative Office of the U.S. Courts reports that during Fiscal Year 2004, there were 14,944 actions filed in the District Courts seeking judicial review of Social Security disability and SSI claims following a final decision of the Appeals Council.

This amount is a relatively modest percentage of the 92,540 requests for review presented to the Appeals Council. I haven't done the math, but I think it is around 17 percent. While the Judiciary recognizes that several factors might explain why the remainder of the claimants chose not to seek review in the Federal Courts, the existence of a right to seek administrative appellate review appears to result in a large majority of claimants not seeking judicial review following receipt of the Appeals Council's final decision. Substituting immediate access to the District Courts prior to the right to request final administrative appellate review, we believe has the potential for significant caseload ramifications for the Federal Courts. The Judiciary understands that SSA intends to gradually roll out the review process region by region, and I was interested in the comments of Commissioner Barnhart a few minutes ago in terms of the speed at which or the timing for the rollout. The SSA also states that it intends to monitor the impact of the process on the courts, and if there are problems, the SSA will promulgate new regulations to address them. We certainly appreciate that.

Chairman HERGER. Mr. McKibben, if you could sum up, please.

Judge MCKIBBEN. Yes I would just summarize by indicating that one of the critical factors I think that we all should look at here is the speed at which there would be a rollout if the SSA decides to go ahead with this process. We believe that there should be at least a year or an 18-month rollout on the first project—pilot project, and call it a pilot project rather than a rollout where they contemplate going one region after another region after another region. I think you need to analyze the data first before there is a determination made that you actually will go to another region, both from the claimant's standpoint and from the standpoint of the impact on the Judiciary. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. McKibben follows:]

Statement of The Honorable Judge Howard D. McKibben, Chair, Judicial Conference Committee, Federal-State Jurisdiction, Administrative Office of the U.S. Courts, Reno, Nevada

Mr. Chairmen and Members of the Subcommittees, my name is Howard McKibben. I am a United States District Judge in the District of Nevada and Chair of the Judicial Conference Committee on Federal-State Jurisdiction. I have been asked to testify today on behalf of the Judicial Conference of the United States regarding the proposed regulations by the Social Security Administration (SSA) to revise the disability claims process. I appreciate the opportunity to be here today, and would ask that my statement be included in the record.

The judiciary commends the SSA for its efforts to improve the quality of agency decisionmaking in connection with claims for disability benefits. Streamlining the decisionmaking process and reducing unnecessary delays in the final disposition of claims is a worthy goal.

We also express our appreciation to Commissioner Barnhart, as well as to her deputy, Martin Gerry, for fostering an open dialogue with the federal judiciary during the development of these regulations. Since 2003, the Committee that I chair has been assessing SSA's ideas for changing the disability claims process. During that time, they have kept us informed and solicited our views on how SSA's proposed changes might impact the dockets of the federal courts. We have met with SSA officials on several occasions, where we tried to learn more about the details of their proposed approach, particularly the latter stages of the review process. At the beginning of this year, our Committee on Federal-State Jurisdiction proposed that the Judicial Conference comment on the SSA approach, which it agreed to do.

At its March 2005 session, the Judicial Conference of the United States, the policymaking body for the federal judiciary, determined to "support efforts to improve the efficiency and effectiveness of the process by which the Social Security Administration considers Disability Insurance and Supplemental Security Income claims, but oppose the elimination of a claimant's right to request review of an administrative law judge's adverse decision by the Appeals Council, or another administrative reviewing unit with comparable authority, prior to seeking relief in federal district court." *Report of the Proceedings of the Judicial Conference of the United States*, March 2005, pp. 18–19. I note that the judiciary is not speaking to the merits of other aspects of the proposed changes to the claims process, and I must emphasize that my comments today are focused on the Appeals Council and the ability of claimants to seek administrative appellate review.

This Conference position was based on statements in the proposed approach calling for the abolition of the Appeals Council and a claimant's right to request review of an administrative law judge's (ALJ) decision by an appellate administrative entity. The proposal would have instead created a quality assurance review unit, which would have been authorized to select certain ALJ decisions for review. Claims involving disagreements between the quality assurance review unit and the ALJ could have been referred to an Oversight Panel for further review. Although some aspects of the approach announced in 2003 were subsequently changed, other concepts remain the same and continue to cause us concern.

Elimination of the Appeals Council and the Establishment of the Decision Review Board

The notice of proposed rulemaking announced by SSA on July 26, 2005 regarding the disability determination process would provide for the elimination of the Appeals Council, and the elimination of the right of the claimant to request adminis-

trative review of disability decisions issued by an ALJ. According to the “Supplementary Information” accompanying the proposed regulations at page 21, SSA expects to gradually shift certain Appeals Council functions to a newly created Decision Review Board (Board).¹ The Board would consist of ALJs and administrative appeals judges and would be responsible for evaluating and reviewing certain ALJ decisions before the decisions are effectuated. § 405.405.

In the Supplementary Information, SSA states that it envisions that the creation of this Board will help “promote the consistency and efficiency of the adjudicatory process by promptly identifying and reviewing, and possibly readjudicating, those administrative law judge decisions that are the most likely to be erroneous.” Supplementary Information at 65. The Board would also be authorized to review claims after the ALJ’s decision has been “effectuated” in order to study the disability determination process. § 405.405(d). The Board may choose to review decisions that are favorable or unfavorable to the claimant. Furthermore, it would be authorized to use any method for selecting cases to review, including random sampling and the use of specific claim characteristics. § 405.410. The proposed regulations would provide that a claimant “may not appeal an administrative law judge’s decision to the Board.”² § 405.405(b).

The Board would apply a “substantial evidence” standard in reviewing the findings of fact made by an ALJ and would review de novo the application of law. § 405.440. The Board could affirm, modify, or reverse the ALJ’s decision. §§ 405.405(b), 405.440. It could also remand a claim to the ALJ for further action and decision. If the Board does not complete action on a claim within 90 days of the date the claimant receives notice of the Board’s review, then the ALJ’s decision becomes the agency’s final decision. §§ 405.415, 405.420.

Claimants would be authorized to file an action in federal district court within 60 days of the date SSA’s decision becomes final and judicially reviewable. § 405.501.

Comments on Elimination of the Appeals Council

The present right of claimants to request review of ALJs’ decisions by the Appeals Council eventually would be eliminated under the proposed regulations. § 405.405(b). This outcome is contrary to the Judicial Conference position favoring preservation of the right of a claimant to request review of an adverse ALJ decision by the Appeals Council, or another administrative reviewing unit with comparable authority, prior to seeking relief in federal district court.

We recognize that SSA has stated that the Appeals Council adds processing time, that it generally supports the ALJ decision, and that it fails to provide meaningful guidance to ALJs when it disagrees. The judiciary, however, believes that the proposed acceleration of district court review of disability claim denials may result in more costs and further delays for claimants because it merely shifts the time for considering such claims from the administrative process to the courts. It could also greatly expand the number of appeals to the federal courts.

Based on information provided by SSA, the ability of claimants to request review by the Appeals Council appears to provide a helpful screening function today. Between October 2003 and September 2004 (FY 2004), SSA reports that the Appeals Council received 92,540 requests for review. Information previously received from SSA suggested that 2% of claims annually are allowed outright by the Appeals Council and 25% are remanded to an ALJ (which often results in allowances to claimants). Thus, the right to request administrative appellate review also appears to result in an award of benefits to a significant number of claimants, without the need for further review by the federal courts.

The Administrative Office of the U.S. Courts reports that during FY 2004 there were 14,944 actions filed in the U.S. district courts seeking judicial review of Disability Insurance and Supplemental Security Income claims following a final decision of the Appeals Council. This amount is a relatively modest percentage of the 92,540 requests for review presented to the Appeals Council. While the judiciary recognizes that several factors might explain why the remainder of the claimants choose not to seek review in federal court, the existence of a right to seek administrative appellate review appears to result in a large majority of claimants not seeking judicial review following receipt of the Appeals Council’s final decision.

¹ The section cites within the proposed regulations are to title 20, Code of Federal Regulations (CFR), which is where regulations presently governing SSA’s disability decisionmaking are located. Parallel references to proposed regulations affecting Supplemental Security Income, also located within 20 CFR, are omitted; however, to the extent that the proposed regulations are the same for SSI decisionmaking, these comments are equally applicable.

² If a claimant’s hearing request is dismissed and the ALJ does not vacate the dismissal, then the claimant may ask the Board to review the dismissal. §§ 405.381, 405.382.

The Judicial Conference believes that preserving the right to request review before an administrative appellate body should continue to be a precondition to federal judicial review. Notwithstanding SSA's position that the proposed changes to the disability claims process will reduce the number of claimants who are dissatisfied with the agency's decision, substituting immediate access to the district courts prior to the right to request final administrative appellate review has significant caseload ramifications for the federal courts.³ The Appeals Council and the proposed Board are specialized tribunals dedicated to reviewing ALJ decisions. The district courts are no less dedicated, but they have diverse responsibilities that make them less suitable for initially reviewing the current 90,000 disability claims of which approximately 75,000 are acted on by the Appeals Council without any federal judicial involvement. Therefore, the federal judiciary would urge that SSA revise the proposed regulations to preserve the present right of claimants to request review of an ALJ decision by an administrative reviewing entity.

SSA's Proposed Implementation of the Elimination of the Appeals Council

The judiciary understands that the proposed regulations do not contemplate the immediate elimination of the Appeals Council in every region. The Supplementary Information at page 50 indicates that SSA proposes to eliminate the right of claimants to appeal a disability decision to the Appeals Council only with respect to claims that have been adjudicated in those states where SSA's proposed changes have been implemented. The description also states that the new system will be phased in, starting in smaller SSA regions and in locations with fewer SSA cases being filed in federal court, which will allow SSA time to monitor the impact the new process has on the number of federal cases being filed in that region. *Id.* at 51. The Supplementary Information further indicates that should the proposed changes adversely affect the disability determination process or the federal courts over time, SSA will amend its regulations as necessary. *Id.* at 50–51. SSA also indicates that should the proposed changes cause a significant increase in federal disability case filings, it will make changes to the process as necessary. *Id.* at 51.

Should SSA ultimately decide to replace the right to request review by the Appeals Council with selective review by the Board, such selective review should, at the very least, be limited to a pilot project in a representative region, instead of the planned gradual implementation of the changes region by region as indicated by SSA. Such a pilot project should be conducted over a sufficiently long period of time to permit the collection of reliable statistical data to determine the impact of the proposed changes on the disability determination process, claimants, and the courts.⁴

Conclusion

The Judicial Conference appreciates the opportunity to present its views related to a portion of the proposed regulations. We continue to support efforts to assist claimants and achieve the correct decision as early in the process as possible, while preserving the right of claimants to seek administrative review of an adverse decision of an ALJ by the Appeals Council or another administrative reviewing unit with comparable authority, prior to seeking relief in the federal district court. To avoid the potential for a detrimental impact upon the judiciary, the Judicial Conference urges SSA to revise the regulations so as to preserve a right to request review by the Appeals Council or a similar entity with comparable authority. If SSA, nevertheless, proceeds to pursue elimination of such right, then the Conference would urge that a single pilot project be conducted in a representative region and then thoroughly studied before any roll-out is scheduled or any nationwide implementation decisions are made.

³A possible analogy is the judiciary's experience after the Department of Justice implemented new decisionmaking procedures for the Board of Immigration Appeals, which serves as the final review step for administrative consideration of alien removal and deportation cases. These "streamlining" efforts included allowing certain decisions to be made without opinions and permitting summary dismissals. As a result of these efforts, immigration appeals increased nationwide by 232% between 2001 and 2004 (for 12-month periods ending June 30). The Second and Ninth Circuit Courts of Appeals saw immigration appeals increase during this period by 1,396% and 401%, respectively.

⁴The judiciary notes that in 1997 SSA promulgated a regulation to permit the testing of the elimination of the request for Appeals Council review, as well as the testing of other features of a redesign plan for disability claims first announced by SSA in 1994. *See* 62 Fed. Reg. 49,602 (Sept. 23, 1997); 20 CFR §404.966. Although we understand that SSA began testing other aspects of the proposed redesign plan soon thereafter in localities in 10 states, the elimination of the requirement to request Appeals Council review apparently was not tested at least until 2000 when SSA issued notice that such testing would begin. *See* 65 Fed. Reg. 36,210 (June 7, 2000). It is unclear, however, whether such testing actually occurred, and if so, what were the results.

Mr. Chairmen, thank you again for the opportunity to testify and present these views of the Judicial Conference. I would be pleased to answer any questions you or the other Members of the Subcommittees may have.

Chairman HERGER. Ms. Ford to testify.

STATEMENT OF MARTY FORD, CO-CHAIR, SOCIAL SECURITY TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES

Ms. FORD. Thank you, Chairman Herger, Chairman McCrery, Members of the Subcommittees, for this opportunity to testify. The Social Security Task Force of the Consortium for Citizens with Disabilities applauds Commissioner Barnhart for establishing improvement of the disability determination process as a high priority. She has sought input from all interested parties, including beneficiaries and consumer advocates, which we very much appreciate. We strongly support efforts to reduce unnecessary delays for claimants to make the process more efficient so long as it will ensure fairness and protect the rights of people with disabilities.

Changes at the front end of the process are critical. Making correct disability determinations at the earliest possible point can help eliminate backlogs and delays later in the appeals process. We support the Commissioner's efforts to improve the front end of the process and believe that this is where the real-time savings will be. This includes technological improvements such as the electronic disability folder. We also support the SSA's work opportunity demonstration projects and look forward to the results. Within this NPRM, there are proposals which we believe will improve the process for people with disabilities, including development of a national network of expert medical units, the elimination of the reconsideration step, and the quick decision process. However, we have grave concerns about the impact of the proposed regulations on the appeals process. Our concerns fall into several areas.

The overall impact of the new time limits imposed on claimants with limited opportunities to show good cause for failure to meet them could result in unfair and unjust decisions, which rest on technicalities and not on the truth of whether the individual is actually disabled. The new requirement to specify all issues on appeal at the time of filing for appeal creates new opportunities for claimants to make irreparable errors. The new requirement to submit all evidence available to you, including adverse evidence or evidence considered unfavorable raises new legal issues for both the claimant and attorney representatives. The appeals process offers no recourse for claimants' difficulty in obtaining evidence from medical and vocational sources, for claimants to seek correction of mistakes or errors made by SSA or the ALJ, or for addressing abusive discretion by ALJs. Some proposed changes may exceed the Commissioner's authority under the Social Security Act (P.L. 74-271).

Throughout, there appear to be some underlying assumptions with which we disagree. First, that the claimant or representative has control over the sources of medical or vocational evidence. Even for representatives, it can be difficult to obtain medical evidence from most treating sources and medical institutions. Second, there

is an assumption that a claimant is represented from the beginning of the process. The reality is much different. People often do not seek representation until later, not understanding how important it can be until it is explained to them for the first time at the ALJ level. A third assumption is that diagnosis is simple and straightforward. Many people have medical conditions that are hard to diagnose, such as Lupus or Multiple Sclerosis. Others have impairments that make it more likely they will fall into procedural cracks in the system, especially those with mental impairments or cognitive impairments.

The answer to denial of benefits when people fail to meet the time lines is not that the person can always reapply. In Title II, where insured status for disability benefits is critical, a person may be barred by the recency of work test from succeeding on a later application. While it is appropriate to deny a claim because the evidence establishes that the claimant does not meet the statutory definition of disability, it is wrong to deny benefits to an otherwise eligible person who falls between the procedural cracks or who is unable to submit relevant evidence because of procedural limitations.

The goal is to have the right decision, not just a legally defensible decision. Decisions must not be based on a collection of technicalities. People need to know that their claims were fairly considered based on all of the evidence, medical and otherwise. We will submit more detailed analysis and recommendations to Commissioner Barnhart prior to the close of the public comment period. We will submit those comments to these Subcommittees also. As you have heard, there are many positive developments at the SSA as a result of the Commissioner's leadership. Even without these proposed procedural changes, steps the Commissioner has already taken will decrease processing times and improve decisional quality—and she has mentioned today that that has already happened. We appreciate that the Commissioner has sought our input and look forward to continuing to communicate with her about steps needed to ensure that new procedures protect claimants and do not result in creating barriers to fair and complete decisions based on the merits. Thank you.

[The prepared statement of Ms. Ford follows:]

Statement of Marty Ford, Co-Chair, Social Security Task Force, Consortium for Citizens with Disabilities

Chairman McCrery, Chairman Herger, Representative Levin, Representative McDermott, and Members of the Subcommittees, thank you for this opportunity to testify on the proposal to revise the disability determination process embodied in the notice of proposed rulemaking (NPRM) for the Administrative Review Process for Adjudicating Initial Disability Claims; Proposed Rule, 70 *Federal Register* 43590 (July 27, 2005).

I am a member of the policy team for The Arc and UCP Disability Policy Collaboration, which is a joint effort of The Arc of the United States and United Cerebral Palsy. I am testifying here today in my role as Co-Chair of the Social Security Task Force of the Consortium for Citizens with Disabilities. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

Throughout the development of this proposal, we have applauded Commissioner Barnhart for establishing improvement of the disability determination process as a

high priority. We have also applauded her work in making the design process an open one. She has sought the comments of all interested parties, including beneficiaries and consumer advocacy organizations, in response to her initial draft.

As we testified before you last year, it is critical that SSA improve its process for making disability determinations. People with severe disabilities often are forced to wait years for a final decision. This is damaging not only to the individual with a disability and his or her family, but also to public perception of the integrity of the program. Last year, we stated:

We strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as the steps proposed do not affect the fairness of the process to determine a claimant's entitlement to benefits. Further, changes at the "front end" can have a significant beneficial impact on improving the backlogs and delays later in the appeals process, by making correct disability determinations at the earliest possible point. Emphasis on improving the "front end" of the process is appropriate and warranted, since the vast majority of claims are allowed at the initial levels. Any changes to the process must be measured against the extent to which they ensure fairness and protect the rights of people with disabilities.

We have conducted an initial review of the NPRM based on the above principles: making the process more efficient and making correct decisions earlier in the process so long as the changes ensure fairness and protect the rights of people with disabilities. I will discuss our initial conclusions and recommendations for changes in this testimony. We will, of course, submit more detailed analysis and recommendations to Commissioner Barnhart before the close of the public comment period and we will submit those comments to the Subcommittees, also. It is possible that our continued work may result in additional recommendations not identified at this point.

As noted, we applaud the Commissioner's efforts to improve the "front-end" of the disability determination process. This includes efforts to implement technological improvements, including the electronic disability process, eDIB, and improving development of the application and the supporting evidence. While these improvements have great potential for improving the adjudication process and are critical to the success of the system, it is important to understand that they are already underway and are not the subject of this NPRM.

General Comments

The CCD Social Security Task Force believes that there are several proposals within the NPRM which could be improvements to the program from the perspective of people with disabilities. These include development of a national network of expert medical units, the elimination of the reconsideration step, and the quick decision process. However, we have grave concerns about the impact on people with disabilities of proposed regulations in the appeals process from the reviewing official stage to the administrative law judge level, to the decision review board level and the elimination of the Appeals Council.

Our concerns about the appeals process fall into several overall areas:

- The overall impact of the new time limits imposed on claimants, with no opportunities to show good cause for failure to meet those time limits, could result in unfair and unjust decisions which rest on technicalities and not on the truth of whether the individual is actually disabled. In addition, even "good cause" rules are insufficient because that means that the discretion lies with SSA or an ALJ to decide whether to accept the evidence, rather than ensuring that the evidence will be considered in deciding the claim. (A chart comparing the current statutory and regulatory time limits to the proposed regulations is attached as Appendix A.)
- New requirements to specify issues on appeal at the time of filing the appeal create new opportunities for claimants to make irreparable errors in the process.
- The new requirement to submit all evidence "available to you," including adverse evidence or evidence the claimant considers "unfavorable," raises new legal issues for both the claimant and attorney representatives.
- The appeals process offers no recourse for claimants' inability to access evidence from medical and vocational sources.
- The appeals process offers no recourse within SSA for a claimant to seek correction of mistakes or errors made by SSA or the ALJ.
- The appeals process offers no recourse for addressing abuse of discretion by an ALJ.

- Some proposed changes may exceed the Commissioner's authority under the Social Security Act.

On the whole, the requirements of the appeals process seem to assume that the claimant and/or the representative have some level of control over the sources of medical or vocational evidence. The proposed timelines for submission of evidence are strict and, in our opinion, unreasonable. Even for representatives, it often can be difficult to secure medical evidence from most treating sources and medical institutions. They may wait weeks or months for the evidence to be produced by the treating source. It is even harder to secure evidence more than once from the same source. For claimants to be permanently harmed by this inability to access evidence completely undermines the concept of a system that is intended to be non-adversarial and to assist them in a time of great need. It is important that any changes maintain the non-adversarial nature of the process and that the procedures and their outcomes are fair and perceived as fair. Even with representation, people who have low or no incomes or only modest incomes—even those with regular medical homes—have trouble securing the medical evidence they need to prove their cases.

The proposed regulations also seem to assume that a claimant is represented from the beginning of the process. Reality is much different. People often do not seek representation until late in the process, not understanding how important it can be. Based on experience, many representatives believe that they would not be consulted until many of the filing deadlines in the proposed regulations are imminent or gone. Under current law, late filings are possible with a showing of “good cause.” The proposed regulations would prohibit such filings. Even when contacted before the deadline, many representatives will not have enough notice about the issues in the case to be able to file notice about the issues for appeal.

Many people with disabilities who apply for disability benefits have medical conditions that are hard to diagnose or for which diagnosis may come late in the process—such as lupus or multiple sclerosis. Others have impairments that make it more likely they will fall into any procedural cracks in the system, especially those with mental impairments and cognitive impairments. As the Congress has already made clear in legislation, it is not acceptable to say that a person who loses his/her appeal can always reapply. Especially in Title II, where insured status for disability benefits is different from insured status for retirement benefits as a result of the recency of work test, a person may be barred by the recency of work test from succeeding on a later application regardless of the condition worsening or the existence of new impairments.

Any regulatory changes should comply with the Social Security Act and should not undermine the confidence that the public has in the Social Security appeals process. For decades, Congress, the United States Supreme Court, and SSA have recognized that the informality of SSA's process is a critical aspect of the program. Creating unreasonable procedural barriers to eligibility is inconsistent with Congress' intent to keep the process informal and non-adversarial, and with the intent of the program itself, which is to correctly determine eligibility for claimants, awarding benefits if a person meets the statutory requirements.

While it is appropriate to deny a claim because the evidence establishes that the individual does not meet the statutory definition of disability, it is wrong to deny benefits to an otherwise eligible individual with a disability who falls between procedural “cracks” or who is unable to submit relevant evidence because of procedural limitations.

Electronic File

The electronic file has an important role in eliminating delays and dramatically improving processing times. The work SSA has underway to put in place an electronic application process and an electronic disability file will eliminate a lot of the delay. This will greatly facilitate movement of files from one part of SSA to another, reduce or eliminate loss of evidence, and probably most important, reduce or eliminate the loss or misplacement of entire case files. All of these problems can add weeks, months or years to processing time. While this work is being accomplished separate from this NPRM, it is important to factor it into any analysis about additional steps, if any, that may be needed to improve the process.

Initial Determination Level

We support SSA's proposal to process “Quick Disability Determination” cases within 20 days for those cases with a high probability of meeting the statutory definition. We also support having the claim go through the normal process if the 20 day limit or the criteria cannot be met. This step should assist those individuals whose cases could be satisfactorily handled quickly by removing them from the lengthier administrative procedures.

We support establishment of a Federal Expert Unit (FEU) to provide medical, psychological and vocational expertise to disability adjudicators at all administrative levels¹ and to oversee a “national network” (NN) of the medical, psychological, and vocational experts.² We support the requirement that the NN experts meet qualifications set by SSA and that NN experts, which can include state disability determination service (DDS) physicians if they meet SSA qualifications, will be paid at rates established by SSA. We believe that these steps could lead to better quality evaluations and the use of vocational expertise earlier in the process.

Recommendation: We recommend that qualifications for consultative examiners (CEs) and rules for referrals to CEs be included in these regulations or that SSA issue changes in this area as soon as possible. It is our understanding that SSA has work underway on these issues.

Reviewing Official

We support the elimination of the reconsideration step at the DDS level. We also support establishment of the Federal Reviewing Official (RO)³ as an attorney with knowledge of Social Security law, regulations, and policies.

However, in requiring the RO to consult with the federal expert unit/national network, the proposed regulations raise the question of who is making the decision at the RO level—the RO or the medical/vocational experts—or whether this creates a bias in favor of affirming the DDS decision.

We disagree with the requirement that the claimant submit new evidence at the same time as filing the notice of appeal to the RO (Sec. 405.215). As discussed above, claimants may not be able to gather all evidence within the specified time-frame.

Recommendation: We recommend that claimants be allowed to submit new evidence when it is available and that the regulations make clear the affirmative obligation of the RO to assist in securing needed evidence.

Administrative Law Judge

We support the goal (although it is not a substantive right) that the Administrative Law Judge (ALJ) hearing will be held within 90 days of requesting the hearing and that the hearing notice will be sent 45 days before the hearing.

However, we have many serious concerns about new requirements at the ALJ stage of appeal. These include new time limits without good cause exceptions; submission of *all* new evidence 20 days before the hearing; and submission of issues for review at the time the appeal is filed.

Time limits: There are many new time limits (beyond the normal appeal deadlines) that make the process overly complicated. Many of the time limits have no “good cause” extension: 10 days to object to time or place of hearing [§ 405.317(a)]; 10 days to object to issues in hearing notice [§ 405.317(b)]; 10 days to submit new evidence after hearing decision [§ 405.373(a)]; 10 days to ask ALJ to vacate dismissal [§ 405.382(a)].

Under the proposed regulations, the record essentially closes 20 days before the hearing with limited exceptions. Proposed § 405.331. This means that the ALJ has the discretion to ignore any evidence submitted within 20 days of the hearing, regardless of its relevance or importance, or that it was beyond the claimant’s control to obtain the evidence. What if the claimant obtains representation within fewer than 20 days of the hearing? The case law in all areas of the country is clear that it is the ALJ’s duty to develop the evidence. The NPRM ignores this. Further, the statute requires the ALJ to decide based on all evidence “adduced at the hearing.”

Submission of evidence: The claimant must submit all evidence “available to you.” Proposed § 405.331. This includes adverse evidence. According to proposed §§ 404.1512(c) and 416.912(c), all information needed to decide the claim must be submitted, including “evidence that you consider to be unfavorable to your claim.” According to the NPRM preface: “This rule will require you to submit all available evidence that supports the allegations that form the basis of your claim, as well as all available evidence that might undermine or appear contrary to your allegations.” 70 Fed. Reg. 43602. We are concerned that this could trip unsuspecting claimants, especially those who are unrepresented. In addition, there is potentially a serious conflict here with state bar rules for attorneys limiting the submission of evidence that could be considered adverse to a client. The determination of what evidence should have been submitted and what “available” means could become a body of law in itself.

¹ See proposed section 405.10.

² See proposed section 405.15.

³ The RO-level proposed changes are at sections 405.201–405.230.

Submission of issues for review: Under the proposed regulations, the claimant would be required to state the issues upon which s/he seeks review. We are concerned that this may foreclose issues which emerge or become clearer as evidence is obtained or further examined. In addition, any penalties for failure to properly or fully raise issues would fall especially harshly on claimants who are unrepresented at the time they file an appeal and who may not understand the implications of this requirement. With this requirement, the process becomes more sophisticated and more adversarial. The outcome will be more decisions denying benefits on technical grounds, not on the merits of the person's claim.

Other procedural problems include:

- The 20-day submission of evidence requirement negates the advantages of the 45-day hearing notice requirement.
- Failure to appear (often for very legitimate and unavoidable reasons) at pre- and post-hearing conferences can lead to dismissal of the case.
- Other procedural rules make the process overly formal: the ALJ may "order" submission of "prehearing statements;" documents other than evidence must be "clear and legible to the fullest extent practicable" and "must use" 12 point font.

Closing the record to new evidence: After the ALJ decision, there are extremely limited exceptions and procedural requirements for submitting new evidence. Proposed § 405.373.

- Unless there is a change in the claimant's condition between the hearing and the decision, the claimant **must** first ask the ALJ to keep the record open at the hearing **and** show "good cause" for missing that deadline. The preface limits this latter exception to situations where the claimant is aware of additional evidence or is scheduled for further evaluation and requires the ALJ to be informed at the hearing. Note that even if requested, the ALJ is not required to keep the record open and has full discretion to deny the request.
- To submit such evidence, the individual must make the request and submission within 10 days after receiving the decision. There is **no** "good cause" extension of this time limit.

These hurdles are impractical and daunting and essentially impede the ability to present evidence that could prove that an individual is eligible. We find it unfathomable that there would be a reason to keep such evidence out of the process when it could provide the very information for which the truth-seeking process is intended.

This stage in the appeals process is so important to claimants that we find it important to stop and ask two critical questions:

Why is closing the record unfair to people with disabilities? There are many legitimate reasons why evidence is not submitted earlier and thus why closing the record or creating unreasonable procedural hurdles is not beneficial to claimants. Why is it important to allow individuals to submit new evidence? (1) The process should be informal; (2) Medical conditions change; (3) The ability to submit new evidence is not always in the claimant's control; (4) Filing a new application is not a viable option (see below); and (5) There are more benign ways to limit the submission of new evidence, such as those in the current process at the Appeals Council and court levels.

Why is reapplying not a viable option? The preface states that if the claimant cannot submit new evidence, he or she has the right to file a new application. 70 Fed. Reg. 43597. This is misleading and inaccurate and may permanently foreclose eligibility: (1) Benefits would be lost from the effective date of the first application; (2) In Title II cases, Medicare would be delayed and the person could lose disability insured status and not be eligible at all if a new application is filed; (3) If the issue in the new application is the same as in the first, the doctrine of "res judicata" bars consideration of the second application; and (4) Congress previously passed corrective legislation on this very issue because in the past, SSA notices misled claimants regarding the adverse effect of reapplying instead of appealing.⁴ At least 15 years after Congress acted on this, it is troubling to realize that the concept is still imbedded in SSA's thinking (and used as a justification here for preventing consideration of all of the evidence even if it is filed a little late).

Recommendations: Restore the timeframes for appeals and rules for submission of new evidence of the current regulations.

⁴ 42 U.S.C. §§ 405(b)(3) and 1383(c)(1).

Decision Review Board

We believe that it is not wise to eliminate the Appeals Council (AC) and its most important function—review of appeals filed *by claimants* from unfavorable ALJ decisions—at this time. Right now, the AC remands close to one-quarter of the cases it sees to the ALJs and it also reverses a small number of cases outright (about 2 percent). The electronic process that SSA already is implementing should eliminate one of the key problems that have plagued the AC for years: lost files.

SSA proposes to eliminate the AC and create a Decision Review Board (DRB). Individuals would not be able to file an appeal to the DRB on the merits of their claim. (SSA does protect the ability of individuals to appeal in cases where an ALJ dismisses a case, as these appeals cannot be filed in federal court.) The only cases that the DRB will review on the merits are those which an SSA computer profiling system identifies as cases in need of review. If the DRB plans to review the case, the person will be notified of this fact at the time that s/he receives his/her ALJ decision.

It is unquestioned that eliminating the AC will result in an increase in the number of cases filed in federal court. At the same time, it also is likely that many people will not file in federal court due to the cost or because filing in federal court is a fairly intimidating act to consider. This means that, in most cases, the unreviewed ALJ decision will be the final decision.

Recommendations: SSA should not repeal the regulation that established the Appeals Council at this time. SSA apparently looked at this issue as part of its “prototype” pilot, but cannot produce any information on the outcomes of eliminating the AC and going straight to court. Should SSA want to proceed with another pilot, that would be far more desirable than eliminating the AC at this point. In addition, since SSA is only planning to roll this entire process out in a couple of regions in 2006, there is time to do such a pilot and evaluate the results prior to deciding whether to issue a second NPRM that might eliminate the AC at a future point.

If, however, SSA intends to proceed to eliminate the Appeals Council at this time, we offer two proposals to modify the proposed Decision Review Board to ensure that it protects the ability of people with disabilities to have their cases fully and fairly considered by SSA.

First, we propose that the new Decision Review Board be modified to provide that it will receive, consider, and decide appeals by claimants and beneficiaries from unfavorable ALJ decisions. Under our proposal, if the DRB failed to act within a specified time, it would issue a “right to sue” letter which the person could use to seek judicial review in federal court. (The claimant could elect to wait for the final DRB decision prior to deciding whether to seek judicial review or seek review within a fixed time period upon receiving the “right to sue” letter.) Claimants would retain their ability to secure review within SSA and the proposal would ensure that the internal SSA process is meaningful and efficient. The DRB would still continue to review the case and issue a decision after the right to sue letter has been issued. If the claimant had not filed suit after receipt of the “right to sue” letter, s/he could decide to file suit after the DRB issues its decision, if needed. Meanwhile, SSA could retain the new functions it proposes for the DRB, reviewing both allowances and denials based on a computer screening tool, and also meet the Commissioner’s in-line quality assurance goals.

How would this proposed change help?

- Provides claimants the benefit of a chance for additional review within the agency—preserves this current, very important protection.
- Incorporates a time limit for how long most cases could be pending at this level, addressing a very common complaint about delays at the Appeals Council level.
- Provides SSA with the ability to identify cases it would not like to defend in federal district court and the opportunity to identify and solve issues that should not require district court review. (It is not reasonable to expect that its computer screening tools will do this.)

Our second proposal would require that the Decision Review Board review cases in which relevant evidence becomes available *after* the ALJ decision to determine whether it should be considered in the claimant’s case. Under the proposed regulations, SSA makes it very difficult, often impossible, for evidence to be considered after 20 days before the hearing. SSA should establish a process that allows the claimant to ask the ALJ to reopen the record *or* allows claimants to show that there is new and material evidence and good cause why it was not offered below. Some claimants would opt to return to the ALJ. Even so, there will need to be a mechanism for some claimants to request that the DRB require that the new and material

evidence be considered. Further, there needs to be a way to address the problem of the ALJ who will not honor the request to keep the record open to file additional evidence. If SSA does not include such a mechanism, many claimants will have to file in federal court simply to secure consideration of evidence that is new and material and for which there is good cause that it was not filed earlier. (The statute says that the courts can make such a remand “at any time.”) The result will be more delay as federal courts order cases remanded back for new ALJ hearings.

Reopening

The proposed regulations severely limit a claimant’s right to request reopening.⁵ The current regulations allow a claimant to request that SSA reopen a decision within one year of the initial determination “for any reason” or to reopen for “good cause” within two (SSI) or four (Title II) years of the initial determination. “Good cause” includes “new and material evidence.” Instead, under the NPRM, reopening could only be requested within **six months** for two situations: (a) clerical error in computation of benefits or (2) clear error on the face of the evidence. There would be no opportunity to reopen for “any reason” or for “good cause” including to consider “new and material evidence.”

Reopening a prior application can be very important for people with disabilities who clearly meet the disability standard but were unable to adequately articulate their claim in the first application, were unable to obtain evidence, or have an impairment that is difficult to diagnose, such as multiple sclerosis or certain mental impairments. Unrepresented claimants with mental impairments frequently reapply instead of appealing and eventually their representatives, on a subsequent claim, will obtain new and material evidence that established disability as of the earlier application. For the same reasons discussed above, reapplying is not a viable option.

Recommendation: We recommend that the current provisions that allow for reopening within one year for any reason or within two years (SSI) or four years (Title II) for good cause, which includes “new and material evidence,” be retained.

Judicial Review

The claimant still has a right to appeal the Commissioner’s “final decision” (either the ALJ or DRB decision) to federal court.⁶ This level of review is generally not affected except as it could be impacted by the other procedural changes, primarily the elimination of claimant-initiated Appeals Council reviews.

We are concerned that more cases will have to be filed in federal court because ALJs will have more authority to ignore new and material evidence submitted within 20 days of a hearing or later. Under current law, a court may remand a case if there is “new and material” evidence and there is “good cause” for not submitting it earlier.⁷ While it remains to be seen how the courts would respond if the ALJs or DRB refused to consider such evidence, it is likely that the number of court appeals will increase requesting that courts exercise their statutory authority. Further, there will be more court remands to the agency for consideration of evidence that should have been part of the administrative record in the first place.

Authority within the Social Security Act

While we support the Commissioner in her efforts to improve the disability determination process and to shorten the length of time that it takes to get a final decision in a case, we are concerned that some of the proposed regulations may go beyond the authority granted to the Commissioner by the statute. Our concerns are as follows:

While broad, there are limits to the Commissioner’s authority: Section 205(a) of the Social Security Act, 42 U.S.C. § 405(a), provides: “The Commissioner shall have full power and authority to make rules and regulations and to establish procedures, *not inconsistent with the provisions of this title*, which are necessary or appropriate to carry out such provisions, and shall adopt *reasonable* and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.” (emphasis added)

Requiring that evidence be filed 20 days before the hearing and that the person identify all issues in the notice of appeal appear to violate the statute: Section 205(b) requires that if a person disagrees with the Commissioner’s decision, “the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a

⁵ The proposed changes in reopening are at sections 405.601 and 405.605.

⁶ See proposed section 405.501.

⁷ 42 U.S.C. § 405(g).

hearing is held, *shall, on the basis of evidence adduced at the hearing*, affirm, modify, or reverse the Commissioner's findings of fact and such decision. . . ." (emphasis added)

If courts can require SSA to take new and material evidence at any time, how can SSA limit taking such evidence within its administrative process? Will individuals with disabilities really have to go to federal court to get an order telling SSA to consider the evidence? Section 205(g) provides that a federal district court "may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding. . . ."

Congress has already made clear that it is concerned when SSA encourages people to reapply for benefits rather than appeal, one of the justifications used in the preface to the NPRM. Section 205(b)(3)(A) provides: "A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for a denial of a subsequent application for any benefit under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221."

Further, section 205(b)(3)(B) provides: "In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Commissioner of Social Security shall describe in clear and specific language the effect on possible entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination."

These provisions exist because SSA used to regularly tell people that they need not appeal their reconsideration decisions, they could simply reapply at some point. In the Disability Insurance program, this can result in ineligibility due to loss of insured status. In addition, in both SSI and DI, this will mean loss of benefits for the period based on the first application until the second application is filed. It is not acceptable for SSA to be incorporating this justification into the NPRM as a basis for explaining that, if a person falls into the various new procedural cracks being created, it is not a problem, because they can always reapply. That is incomplete and misleading.

Conclusion

While justice delayed can be justice denied, justice expedited also can result in justice denied. At the end, the goal is to have the right decision, not just a legally defensible decision. And, to be fair, decisions cannot be based on a collection of technicalities such as failure to file evidence by a specific time or failure to file a detailed list of issues related to an appeal—people need to know that their claims were fairly considered based on all of the evidence, medical and otherwise.

As organizations representing people with disabilities, we strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient. However, these changes should not affect the fairness of the process to determine a claimant's entitlement to benefits. As noted above, the CCD Task Force will submit more detailed analysis and recommendations to Commissioner Barnhart prior to the close of the public comment period and we will submit those comments to the Subcommittees, also.

ON BEHALF OF:

American Association of People with Disabilities
 American Association on Mental Retardation
 American Council of the Blind
 American Foundation for the Blind
 Bazelon Center for Mental Health Law
 Easter Seals, Inc.
 Epilepsy Foundation
 Inter-National Association of Business, Industry and Rehabilitation
 National Alliance for the Mentally Ill
 National Association of Councils on Developmental Disabilities
 National Disability Rights Network, formerly National Association of Protection and Advocacy Systems

National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
The Arc of the United States
Title II Community AIDS National Network
United Cerebral Palsy
United Spinal Association

CURRENT PROCESS TIME LIMITS	NPRM: CLAIMANT TIME LIMITS	NPRM: SSA TIME LIMITS
<i>File initial application</i> 60 days to appeal	<i>File initial application</i> 60 days to appeal	<ul style="list-style-type: none"> • 20 days to make “quick decision” • No time limit if not “quick decision”
<i>Reconsideration</i> <ul style="list-style-type: none"> • Claimant has “opportunity to present additional evidence.” No time limit. Decision based on “all of the evidence.” 20 C.F.R. § 404.913(a). 60 days to appeal	<i>Reviewing Official</i> <ul style="list-style-type: none"> • Must submit new evidence with appeal—§ 405.215. • But see § 405.210(a)(4): You “should” (but not “must”) include with your appeal request “[a]dditional evidence that you have available to you” 60 days to appeal	<ul style="list-style-type: none"> • Decision: No time limit
<i>Administrative Law Judge</i> <ul style="list-style-type: none"> • Object to time or place of hearing “at the earliest possible opportunity” 20 C.F.R. § 404.936. • Object to issues in hearing notice “at the earliest possible opportunity.” 20 C.F.R. § 404.939. Submit new evidence: <ul style="list-style-type: none"> • 42 U.S.C. 405(b)(1): Right to hearing with decision based on “evidence adduced at the hearing.” • “At the hearing” you may submit new evidence. § 404.929. • “If possible” submit 10 days after filing Request for Hearing. Party “shall make every effort” to be sure that all material evidence is received by the ALJ or is available at the time of the hearing. § 404.935. • Right to appear before ALJ “to present evidence.” 20 C.F.R. § 404.950. • After hearing decision: can submit Appeals Council (see below) • Request ALJ to vacate hearing dismissal: 60 days (or appeal to Appeals Council). 20 C.F.R. § 404.960. 60 days to appeal	<i>Administrative Law Judge</i> <ul style="list-style-type: none"> • Object to time or place: 10 days after Notice (no good cause). § 405.317(a). • Object to issues in Notice: 10 days after Notice (no good cause). § 405.317(b). Submit new evidence: <ul style="list-style-type: none"> • Before hearing: Per § 405.331, must submit all new evidence (both favorable and unfavorable) 20 days before hearing UNLESS <ul style="list-style-type: none"> • Good cause; or • Material change in condition • After hearing decision: Per § 405.373(a), must request permission to submit new evidence after hearing decision: 10 days after hearing decision (no good cause). Not considered if submitted late. Claimant must show: <ul style="list-style-type: none"> • Unforeseen and material change in condition between hearing and decision; or • At hearing, request to keep record open, ALJ agreed, and good cause for missing date • Request ALJ to vacate hearing dismissal: 10 days (no good cause). § 405.382(b). 60 days to appeal—dismissals only	<ul style="list-style-type: none"> • Goal: Hold hearing in 90 days • Hearing Notice: 45 days before hearing. § 405.315(a). • Hearing decision: No time limit

CURRENT PROCESS TIME LIMITS	NPRM: CLAIMANT TIME LIMITS	NPRM: SSA TIME LIMITS
<p>Appeals Council</p> <ul style="list-style-type: none"> Initiating Appeals Council own motion review: Within 60 days after ALJ decision. § 404.969. Note: 42 USC § 423(h) and 20 CFR § 404.969 require payment of interim benefits if “final decision” not issued within 110 days after favorable ALJ decision. Submitting new evidence: “Shall” consider all new and material evidence submitted which relates to the period on or before the ALJ decision. 20 C.F.R. §§ 404.970(b) and 404.976(b). To file brief or written statement: “Upon request, claimant given a ‘reasonable opportunity.’” No page limit. 20 C.F.R. § 404.975. <p>60 days to appeal to federal court</p>	<p>Decision Review Board</p> <ul style="list-style-type: none"> Request permission to submit new evidence: 10 days after DRB Notice (no good cause). Same exceptions as post-ALJ decision. § 405.373(b). Request permission to file written statement: 10 days after DRB Notice (no good cause); with appeal (if dismissal). § 405.425. <p>60 days to appeal to federal court (from SSA “final decision”)</p>	<ul style="list-style-type: none"> Screening ALJ decision for DRB review: no time limit. DRB decision: 90 days after Notice of DRB review. If not met, claimant can proceed to file in federal court. § 405.450.
Federal court	Federal court	

Chairman HERGER. Thank you. Mr. McDonald, please testify.

STATEMENT OF DANA E. MCDONALD, IMMEDIATE PAST CHAIR, SOCIAL SECURITY SECTION, FEDERAL BAR ASSOCIATION, ATLANTA, GEORGIA

Mr. MCDONALD. Thank you, Mr. Chairman and Members of the Subcommittee. My name is Dana McDonald of Atlanta, Georgia. I appear here on behalf of the Federal Bar Association’s (FBA) Social Security Section, having served as Chair of that section last year and previously as the National President of the Association. We are honored that you have asked for our participation in your consideration of the Commissioner’s proposed regulations. The FBA has as its members many of the disability stakeholders affected by these regulations—lawyers in private and public practice, as well as judges at all levels of this process.

I have served as an ALJ for the last 11 years, and before that was in private law practice in Atlanta for 17 years. I am one of those in the trenches, so to speak, hearing each year hundreds of disability cases in which the claimant may or may not have representation. At the outset, let me say that the section agrees with the Commissioner’s assessment that there is a need to make substantial changes in the disability determination process. All of us who are concerned with the case backlogs and delays caused by the current system share the belief that justice delayed is, indeed, justice denied. We believe that we can, indeed we must, do better. The Commissioner’s plan leaves us hopeful that deserving Americans will receive their benefits sooner than they do now as a result of the changes we are considering at this juncture.

As you know this is not SSA's first attempt to lessen case processing and streamline the adjudicatory process. Some of those past efforts have been far from successful. However, it is our sense that the current proposed reforms have a better chance of succeeding. The replacement of the current reconsideration process with that of the Reviewing Official (RO) could substantially reduce the number of cases passing on to the ALJs for hearings. If that occurs, the Commissioner's plan will achieve a significant result, as today the number of cases pending before ALJs is nothing short of staggering. In the late '90s, the Atlanta North Office of Hearings and Appeals (OHA) office participated in the adjudication officer pilot program and many found it to be a highly desirable improvement in the disability adjudication process. They were disappointed when the program was discontinued, apparently due to budget constraints. The current proposed plan bears many resemblances to the adjudication officer program, and, for that reason, the section is hopeful that the Commissioner's plan will succeed.

In my written testimony, I have identified the Sections concerned with various aspects of the Commissioner's plan, including the RO, the Disability Review Board (DRB), the closing of the record at the time of the ALJ decision, and the likely consequences of a abolishing the Appeals Council and its impact on the Federal District Courts. The section plans to submit comments to the Commissioner in these areas as well as others, including video-teleconferenced hearings, dismissals, the staged implementation of the DRB and the DRB standards in reviewing ALJ decisions. I would be happy to discuss these matters with your Committee as well. I would like to highlight one of the areas in which we have indicated our concern—review by the DRB.

The DRB provisions in the proposed regulations raise several issues. First, there is no claimant right to request review of an ALJ decision except in one area and that involves dismissals. Thus, the claimant, the adversely affected party, has no administrative mechanism for initiating review of anything other than dismissals. The consequence of that will fall upon the District Courts unless the Commissioner's other reforms succeed in lessening the number of cases reaching the ALJ level in the first place. Second, there is no defined standard for the selection of cases for review by the DRB. Third, the DRB is granted authority, while it is reviewing the case, to itself obtain new evidence. It is permitted to obtain a medical opinion on a case from the FEU. At the time the DRB is permitted to itself obtain and consider evidence, the claimant is prohibited from submitting any new and material evidence. Further, not only is the DRB permitted to obtain evidence, and the claimant prohibited from submitting any new evidence, the DRB is apparently authorized nevertheless to use the new evidence to reverse the ALJ decision in its entirety. It is hard to imagine that such a procedure would pass constitutional challenge by a claimant. We again thank the Committee for this opportunity, and I would be pleased to answer questions or submit written follow up as your Committee may wish.

[The prepared statement of Mr. McDonald follows:]

Statement of The Honorable Judge Dana E. McDonald, Immediate Past Chair, Social Security Section, Federal Bar Association, Atlanta, Georgia

Chairmen McCrery and Herger and Members of the Subcommittees:

I am Judge Dana McDonald, Immediate Past Chairman of the Social Security Section of the Federal Bar Association. I am an administrative law judge in the Office of Hearings and Appeals of the Social Security Administration in its Atlanta North office. As an Administrative Law Judge in the Social Security Administration for the past decade, I have heard and decided thousands of appeals. I am very pleased to be here today representing the Social Security Section of the Federal Bar Association (FBA). My remarks today are exclusively those of the Social Security Section of the Federal Bar Association, not the FBA as a whole. Moreover, they are not intended to reflect the official views or position of the Social Security Administration.

Thank you for convening this hearing this afternoon on a matter of critical importance to the Federal Government's delivery of vital Social Security programs to the American people. As of July 2005, the Social Security Administration's Disability Insurance program provided \$6.2 billion in monthly benefits to more than eight million disabled workers and their families. And by 2013, the SSA expects the DI rolls to grow by 35 percent, due to the retirement of members of the Baby Boom generation. Administration of the Disability Insurance program poses real challenges for SSA, as disability claims increase and pending caseload numbers rise. In prior Congressional testimony, our Section has expressed its deep concern that current delays at the Social Security Administration in the processing of disability claims are unacceptable and that the quality of decisions at all levels is less than ideal. We believe that the satisfaction of SSA's obligation to provide timely and considered review of all disability claims requires a variety of reforms from the state DDS level to judicial review available in federal court.

That is why the Social Security Section of the Federal Bar Association has maintained a longstanding focus on the effectiveness of the disability adjudicatory process, including hearings conducted by the Office of Hearings and Appeals, the appeal process of the Appeals Council and judicial review in the federal courts. We continue to believe that an administrative hearing with due process for the claimant represents the best means to arrive at the correct determination of disability. Our highest priority in connection with our review of the proposed regulations before you today, therefore, has been devoted to the assurance of integrity, independence, fairness, and effectiveness of the Social Security disability hearing process for those it serves—Social Security claimants as well as American taxpayers who have an interest in assuring that only those who are truly disabled receive benefits.

With this in mind, we provide the following comments on the Social Security Administration's proposed regulations, published on July 27, 2005, to improve the disability determination process.

Overall, we believe Commissioner Barnhart is to be applauded for her considerable leadership over the past two years to streamline and strengthen the quality and consistency of disability decisions. The Commissioner has faced a daunting task, and has proposed a comprehensive framework that now deserves careful scrutiny by Congress, stakeholder interests and the American public.

Generally, we believe that the elimination of the "rubber stamp" reconsideration level, as proposed by the regulations, will streamline the process and reduce the time span of a disability claim. The transfer of authority from the Appeals Council to the Decision Review Board should also help to expedite the arrival of a correct, final decision. At the same time, however, we fear that some proposed changes may undermine efforts to develop a full and fair record, as well as the independence and authority of administrative law judges. If our concerns prove correct, the availability of a fair hearing with due process will be lost for some claimants, and their disability applications may not be accurately determined.

Our comments today focus on six areas that are key components of the proposed regulations:

- The role and authority of the Reviewing Official
- Creation of the Federal Expert Unit
- The role and authority of Administrative Law Judges
- The Decision Review Board and the scope of its review
- Reopening of the hearing record; and
- The value of Work Opportunity Initiative demonstration projects

The Role and Authority of the Reviewing Official

Under the Social Security Administration's proposed rules, if a claimant is dissatisfied with the determination made by the state agency, the claimant may appeal the determination to a federal Reviewing Official, who will conduct a review of the

claim. The Reviewing Official will review the state administrative record and issue a decision in the case or return the case to the state agency.

We believe the Reviewing Official can perform a very useful role in acting on initial determinations and assuring the payment of disability benefits to obviously disabled claimants sooner than under the current system. We recommend that it operate in a fashion similar to the former “senior attorney program.” Adequate staffing and resources will be critical to assure accurate and expeditious action by Reviewing Officials on claims.

We have several reactions to the role and authority of the Reviewing Official, as proposed by the regulations. First, we believe that the Reviewing Official should have greater authority than conferred by the Commission’s proposal. Specifically, the Reviewing Official should have the discretion to award benefits without being bound by the proposed regulatory requirement to obtain additional input from a non-examining medical expert. The Reviewing Official’s independent review of the existing record should be sufficient; not all cases should necessarily require the consideration of additional medical evidence. The Reviewing Official should be permitted, of course, to obtain expert opinion from a non-examining physician on an as-needed basis.

Second, although we applaud the use of in-line quality assurance effort, we believe that quality assurance should occur after the Reviewing Official allows or disallows an application for disability benefits. Quality assurance at that juncture will not delay the administrative process. If the claim were not allowed, the claimant could immediately request review through a hearing before the Administrative Law Judge.

Third, the review conducted by the Reviewing Official should not take longer than “reconsideration” does now. And the Reviewing Official’s denial should be entitled to no more weight than a reconsideration denial currently receives from an Administrative Law Judge. The ALJ should neither be permitted to simply adopt the Reviewing Official’s report, nor be expected to have to rebut the RO’s denial. The ALJ is making a *de novo* examination of the evidence and the claim itself.

Fourth, we agree with the proposed regulation that the characteristics of this position are ideally suited for an attorney. The position description of the Reviewing Official should require a law degree as a condition of employment.

Creation of a Federal Expert Unit

The proposed regulation contemplates more extensive use of medical and vocational experts to arrive at just and legally correct decisions, in accord with the meaning of “disability” under the Act. We believe the proper use of medical and vocational experts will contribute to an efficient, accurate and fair adjudication process. The creation of a Federal Expert Unit, to assure that medical, psychological and vocational experts are consistently available to all adjudicators at every level or in all parts of the country, is commendable.

However, we believe that the Social Security Administration may too rigidly and narrowly set the qualification requirements for experts affiliated with the Federal Expert Unit. We believe that qualified experts should be those who possess a combination of clinical and consulting practice experience, or alternatively, extensive clinical experience. For example, a practicing physician from a public hospital is fully capable of making the requisite nuanced judgments about the severity of particular conditions within his area of expertise. Similarly, a vocational expert who currently talks to employers and actually places workers is more knowledgeable than a vocational expert who only testifies at hearings. Some of the members of our Section—particularly Administrative Law Judges and practicing attorneys—have expressed the concern that without extensive clinical experience, medical experts’ opinions will not sufficiently focus on the record of the individual claimant before them and rely more on general medical judgments.

We further believe that vocational experts are best sited not at a centralized location, but instead in the locale from which they will testify. This is especially important because a significant portion of a Vocational Expert’s testimony addresses the presence or absence of jobs within a particular geographic region. The qualifications of vocational experts in the Federal Expert Unit should include practical experience, as well as knowledge of the claimant’s corresponding local job market.

The Role and Authority of Administrative Law Judges

The Administrative Law Judge must be empowered to conduct a full and fair hearing and make a *de novo* decision. To accomplish this, the opinion of the Reviewing Official under the proposed regulations should be given no more weight by the Administrative Law Judge than the reconsidered decision is accorded under the current rules.

The proposed regulations seek to improve the timeliness of the hearing process by revising the rules setting the timeframes for submitting evidence and the closing of the record. We applaud the concept of closing the record at the time of the Administrative Law Judge's decision. However, we are concerned that the 45-day notice of hearing, which effectively allows a 25-day period for the claimant to submit evidence to the ALJ (all evidence must be submitted within 20 days of the hearing), does not provide sufficient time for claimants to gather the relevant evidence. While it is difficult to schedule three months ahead of time, we believe a 90-day notice of hearing is more appropriate. Three months notice is fairer to claimants to permit them adequate time to obtain all appropriate evidence prior to the hearing.

We endorse the regulations' commitment to empower Administrative Law Judges to conduct hearings as the needs of justice require. Adjudicatory fairness requires that ALJ's continue to possess the discretion to keep the record open, to obtain post-hearing consultation evidence, and to contact physicians as necessary. The ALJ must continue to have the duty to assure the development of a full and fair record. We also endorse the regulations' proposed requirement that claimants shall submit appropriate evidence in support of their claim no later than 20 days before hearing, and that the record in the case shall close at the time of the ALJ decision. Our endorsement rests upon the belief, however, that a 90-day notice of hearing (not a 45-day notice) is the better approach, and that more liberal reopening procedures than those proposed are necessary to afford fairness to the claimants. We expect that in the large majority of cases, a claimant will submit all the evidence prior to the hearing, the ALJ will consider it, and the ALJ will promptly issue a correct decision regarding the eligibility of the claimant to benefits. As discussed below, however, there will be situations that cry out for more liberal reopening provisions than those currently proposed.

The Decision Review Board and Its Scope of Review

Our greatest reservations with the regulations rest with the Social Security Administration's proposal to transfer important and critical functions currently performed by the Appeals Council to the Decision Review Board. We agree with SSA that greater focus needs to be placed upon the prompt identification of significant decisional errors and the identification of policies and procedures that will improve decision making throughout the disability determination process.

We believe that appellate review between the ALJ and the federal district court, exercised by an entity such as the Decision Review Board, should exist to correct blatantly obvious mistakes. Without such review, a significant increase in federal court litigation is likely to come about. With this in mind, the scope of Decision Review Board review, we believe, should be expanded to include a mechanism whereby claimants can seek the correction of gross error by an Administrative Law Judge.

Currently, the Appeals Council remands approximately a quarter of the cases where claimants request review. Under the proposed regulations, except in certain limited exceptions, claimants will not have the right to request Decision Board review. We differ with this approach and believe that entitlement to request DRB review should be available to both the claimant and SSA, and that each party should be permitted to comment on the other's review request.

Finally, and most important, we believe the regulations fail to provide sufficient safeguards to guard against the DRB's encroachment upon ALJ independence. We believe that, unless properly checked, quality assurance programs possess the capacity to diminish the fairness and independence of the Administrative Law Judge. The regulations therefore should expressly bar the Decision Review Board from overruling the Administrative Law Judge on findings of credibility or findings of fact. Otherwise, the fairness of the disability hearing process will be in jeopardy. The dividing line between issues of law and issues of fact can be easily blurred in the context of disability adjudication, and we urge that the distinction be sharply and clearly drawn in order to protect claimants from substitution of judgment by the DRB for that of the Administrative Law Judge.

Reopening of the Record

The proposed rules are much more restrictive than the current rules on reopening. There is no provision for reopening when new and material evidence is submitted. Given that the Social Security Administration's proposal envisions that the record will generally close at the time the ALJ issues his decision, and given the strict time limitations on the submission of evidence, the need for reopening is more compelling than it has been in the past.

The proposed regulations are likely to work smoothly for claimants who have the assistance of counsel, but poorly for unrepresented claimants. Claimants without benefit of counsel may not understand their duty to acquire all relevant information

three weeks before a hearing; they may not appreciate the fact that school or mental health records are relevant to a disability determination. We know from experience that in some cases definitive medical tests may not be administered in time until after the ALJ decision, with results that could well lead to a different ALJ decision. Similarly, the participation of new doctors not previously associated in some cases may lead to a new definitive diagnosis of a prior long-standing condition. None of these hypothetical situations necessarily demand re-opening in a legal sense, but fairness dictates, we believe, that an ALJ possess the discretion to review his prior determination in light of these new circumstances. The need to do so is particularly compelling when a claimant's date last insured has expired and benefits can only be allowed by reopening of a prior application. At a minimum, the new regulations should run parallel to the current procedures, found at 20 C.F.R. § 404.988. Under those rules, an ALJ's determination may be reopened within 12 months of the date of the notice of the initial determination—for any reason; and within four years of the date of the notice of the initial determination—if there is good cause. We believe "good cause" should include the submission of new and material evidence, even after a hearing decision. Otherwise, the only alternative available to a claimant with material post-decisional evidence is to file a civil complaint in federal court, where the statutory right to submit new and material evidence exists. If there is not an administrative mechanism to permit the submission of new and material evidence after an ALJ decision, affected claimants will have no forum except federal court for the purpose of evaluating new evidence. The absence of such opportunity is likely to contribute to an increase in federal court litigation, adding unnecessary burdens to claimants and the already over-taxed federal court system.

The Value of Work Opportunity Initiative Demonstration Projects

Finally, we applaud the Commissioner's practical and forward thinking embodied in the three demonstration projects within the Work Opportunity Initiative. These programs offer short-term medical benefits to qualifying claimants as a gateway back to gainful employment. We believe that a sizable number of claimants could rapidly return to work if only they had access to effective medical care. As medical costs continue to rapidly escalate, these demonstration projects may provide a valuable alternative for some claimants on their journey back to gainful activity.

Conclusion

Thank you once again for the opportunity to appear before you today. The Social Security Section of the Federal Bar Association looks forward to working with you and the Social Security Administration in improving the disability hearing process. I would be happy to answer any questions you may have.

Chairman HERGER. Thank you very much. Mr. Marioni?

STATEMENT OF ANDREW MARIONI, PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS, NEW CASTLE, DELAWARE

Mr. MARIONI. Mr. Chairman, thank you for the opportunity to address the Subcommittees on Social Security and Human Resources concerning the proposed regulations to restructure the disability determination process. The National Council of Disability Determination Directors (NCDDD) fully supports the goals of the Commissioner to decrease decision times, streamline procedures and processes, provide for accurate decisions as early in the process as possible, and improve quality and consistency in decisionmaking and accountability enterprise wide. We believe the overall plan is the agency's best effort to date at constructing a process that addresses the stated goals. However, we also believe it can be further improved.

Overall, the proposed regulations contain numerous positive changes that will increase efficiency, accuracy, and consistency. However, we are deeply concerned about the lack of operational detail. Without such detail, we cannot know whether the ultimate ef-

fects will be positive or negative. In the case of the quick disability determinations, for example, the validity and accuracy of the predictive software is crucial to the success of quick decisions. The software's capabilities will need to consider more than alleged impairment. It must consider technical issues, such as date last insured, onset, currency of medical treatment, and case development issues.

The regulations are silent as to how this software will identify appropriate cases for quick decisions. The proposed FEU, which includes State agency medical consultants, can provide many DDS's with additional access to medical and vocational expertise. However, the DDS community is concerned that a rigid approach to establishing qualification standards for inclusion into the FEU may undermine efforts to retain valuable State agency consultants. We believe that programmatic experience and demonstrated performance are the best indicators for qualified Federal experts. The preamble to the proposed regulations calls for a new centrally managed quality assurance system to be applied throughout the disability determination process. A centralized quality function has long been supported by the NCDDD as an effective method to institutionalize uniform policy interpretation and application.

The proposed regulations, however, do not adequately address the longstanding disconnect between policy and the reviewing component of the SSA. We believe there must be an integration of the reviewing component and the policy component to assure uniformity and consistency at all levels of the adjudicative process. As an organization, we are not convinced of the value added to the program by limiting the RO position to attorneys. This requirement effectively excludes many qualified individuals who have extensive experience and expertise in applying the laws and regulations as well as integrating the medical and vocational aspects of the program.

The position should be open and competitive and selection made on the basis of experience and proven performance, not on the type of degree held. The increased administrative costs associated with hiring attorneys should also lead one to question the wisdom of this approach, especially in times of challenging Federal budgets. The proposed regulations are replete with many new mechanisms to assure accountability and consistency in decisionmaking. We cannot neglect to point out the difference in the reviewing standards exercised at the DDS reviewing official and the Office of Hearing and Appeal levels. The regulations require all adjudicative components to use a preponderance of evidence standard. However, only the DDS and reviewing official will be reviewed using the preponderance standard.

We believe there must be uniform standards of decisionmaking and review for all adjudicative levels or risk the failure to achieve improved consistency in decisionmaking. Too often the reins of decisionmaking between adjudicative levels on cases with similar findings is startling. Having a different review standard at OHA will inevitably perpetuate disparate decisions between components. Process and procedural changes of this magnitude must always be considered in light of projected costs. The regulations report an estimated total program cost of \$1.265 billion, with increasing costs

for 10 consecutive years. What is lacking is any real data to support the costs and a discussion of assumptions that were used to conclude the estimated costs. For example, what data was used to predict allowance rates at the DDS, RO, and OHA, which would have a significant impact on program benefit outlays.

In an environment of limited funding, is this affordable? Is it justifiable on a cost-benefit basis? Furthermore, there is no discussion of projected administrative costs, despite the inclusion of two new expensive bureaucracies, the RO and the FEU. The NCDDD believes further study and clarification is needed before the costs can be deemed acceptable. The NCDDD stands ready to work cooperatively with the Commissioner to develop an efficient and cost effective operational plan that will ensure the success of this critical initiative. Mr. Chairman, thank you again for the opportunity to testify.

[The prepared statement of Mr. Mariononi follows:]

Statement of Andrew Mariononi, President, National Council of Disability Determination Directors, New Castle, Delaware

Mr. Chairmen, thank you for the opportunity to address the Subcommittees on Social Security and Human Resources concerning the proposed regulations to restructure the disability determination process.

The National Council of Disability Determination Directors (NCDDD) is a professional association composed of the directors and managers of the 53 Disability Determination Service (DDS) agencies located in each state, the District of Columbia, Puerto Rico, and Guam. Collectively, members of the NCDDD are responsible for directing the activities of nearly 15 thousand employees engaged in processing approximately 4 million claims per year for disability benefits under the Social Security Act. NCDDD's goals focus on establishing, maintaining and improving fair, accurate, timely, and cost-efficient decisions to persons applying for disability benefits. The mission of the NCDDD is to provide the highest possible level of service to persons with disabilities, to promote the interests of the state operated Disability Determination Services, and to represent DDS directors, their management teams and staff.

The NCDDD fully supports the goals of the Commissioner to decrease decision times, streamline procedures and processes, provide for accurate decisions as early in the process as possible, and improve quality, consistency in decisionmaking and accountability enterprise wide. We believe the overall plan is the Agency's best effort to date at constructing a process that addresses the stated goals. However, we also believe it can be further improved.

My purpose today is to provide you with a high level NCDDD perspective on the proposed process revisions. For the past five weeks, six NCDDD committees, representing DDSs in all ten regions of the nation, have been meeting to gather membership input and provide reports and recommendations to the NCDDD leadership on the major components of the new disability determination process. These recommendations will form the basis of the NCDDD's comments to be submitted to the Commissioner within the next several weeks. We look forward to sharing our comments and recommendations with the Subcommittees.

Overall, the proposed regulations contain numerous positive changes that will increase efficiency, accuracy and consistency. However, we are deeply concerned about the lack of operational detail. Without such detail, we cannot know whether the ultimate effects will be positive or negative. In the case of the Quick Disability Determinations, for example, the validity and accuracy of the predictive software is crucial to the success of Quick Decisions. The software's capabilities will need to consider more than alleged impairment. It must consider technical issues such as date last insured, onset, currency of medical treatment and case development issues. The regulations are silent as to how this software will identify appropriate cases for Quick Decisions.

The proposed Federal Expert Unit (FEU), which includes state agency medical consultants, can provide many DDSs with additional access to medical and vocational expertise. However, the DDS community is concerned that a rigid approach to establishing qualification standards for inclusion into the FEU may undermine efforts to retain valuable state agency consultants. We believe that programmatic

experience and demonstrated performance are the best indicators for qualified federal experts.

The preamble to the proposed regulations calls for a new centrally managed quality assurance system to be applied throughout the disability determination process. A centralized quality function has long been supported by the NCDDD as an effective method to institutionalize uniform policy interpretation and application. The proposed regulations, however, do not adequately address the longstanding disconnect between policy and the reviewing component of SSA. We believe there must be an integration of the reviewing component and the policy component to assure uniformity and consistency at all levels of the adjudicative process.

As an organization, we are not convinced of the value added to the program by limiting the Reviewing Official (RO) position to attorneys. This requirement effectively excludes many qualified individuals who have extensive experience and expertise in applying the laws and regulations as well as integrating the medical and vocational aspects of the program. The position should be open and competitive and selection made on the basis of experience and proven performance, not on the type of degree held. The increased administrative costs associated with hiring attorneys should also lead one to question the wisdom of this approach especially in times of challenging federal budgets.

The proposed regulations are replete with many new mechanisms to assure accountability and consistency in decisionmaking. But we cannot neglect to point out the difference in the reviewing standards exercised at the DDS, Reviewing Official, and Office of Hearings and Appeals (OHA) levels. The regulations require all adjudicative components to use a preponderance of evidence standard. However, only the DDS and Reviewing Official will be reviewed using the preponderance standard. We believe there must be uniform standards of decisionmaking and review for all adjudicative levels or risk the failure to achieve improved consistency in decisionmaking. Too often the range of decisionmaking between adjudicative levels on cases with similar findings is startling. Having a different review standard at OHA will inevitably perpetuate disparate decisions between components.

Process and procedural changes of this magnitude must always be considered in light of projected costs. The regulations report an estimated total program cost of \$1.265 billion dollars with increasing costs for ten consecutive years. What is lacking is any real data to support the costs and a discussion of assumptions that were used to conclude the estimated cost. For example, what data was used to predict allowance rates at the DDS, RO and OHA which would have a significant impact on program benefit outlays? In an environment of limited funding, is this affordable? Is it justified on a cost/benefit basis? Furthermore, there is no discussion of projected administrative costs despite the inclusion of two new expensive bureaucracies—the RO and the FEU. The NCDDD believes further study and clarification is needed before the costs can be deemed acceptable.

The NCDDD stands ready to work cooperatively with the Social Security Administration to develop an efficient and cost-effective operational plan that will ensure the success of this critical initiative.

Mr. Chairmen, thank you again for the opportunity to provide this testimony today. I will be happy to answer any questions you may have.

Chairman HERGER. Thank you. Mr. Sutton to testify.

STATEMENT OF THOMAS D. SUTTON, PRESIDENT, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES, TREVOSE, PENNSYLVANIA

Mr. SUTTON. Thank you, Mr. Chairman. Thank you for the opportunity to testify today regarding the Commissioner's proposed regulations. I am the President of the National Organization of Social Security Claimants' Representatives (NOSSCR), the members of which represent claimants in this process and are intimately familiar with its problems. We are supportive of the Commissioner's effort to streamline this process, especially including the electronic folder, and we think it will do a lot of good. However, we are very concerned about some aspects of her proposal, due to some unin-

tended consequences that will do great harm to the rights of our disabled clients.

In fact, under these proposed rules, we believe that a significant number of claimants who are disabled will be denied benefits simply because they were unable to produce all of their medical records in time to meet the deadlines. The records that proved their disability will never be considered on appeal. I want to highlight three particular problems with the proposed rules. First, claimants would have the right to submit evidence only until 20 days before the hearing. After that, ALJs would consider evidence only if they found good cause for its late submission. This is an unprecedented change, which we believe is inconsistent with the Social Security Act, which provides the decisions are to be made based on “evidence adduced at the hearing.” We also believe that compliance with this regulation will prove to be extremely difficult in many cases. In my own small law firm, we employ people full time just to gather medical records for our clients. Even with significant resources devoted to this task, however, we are often unable to submit records prior to the hearing because medical providers are so slow to respond.

When clients retain our services with little time remaining before the hearing, the task of obtaining these records becomes even more arduous. For those claimants who never find counsel and attempt to represent themselves, obtaining complete medical records is virtually impossible due to lack of knowledge and inadequate funds to pay copying services. Under these rules, claimants will have less than 25 days after receiving notice of a hearing date to submit all updated medical records. Nothing in the law requires medical providers to turn over records this quickly, so claimants will be at the mercy of ALJs to find good cause if they don’t have all the records. Some will do so. Other ALJs may rigidly enforce the new 20-day deadline, leading to the following nightmare scenario: The claimant hires an attorney when she receives a notice 45 days before the scheduled hearing. The attorney locates recent medical records which show that what was previously unexplained, severe fatigue is actually caused by multiple sclerosis. The records are only received in time to submit them to the ALJ 10 days before the hearing rather than 20 days before.

The ALJ rules that the claimant should have obtained the records herself or retained counsel earlier and refuses to consider the updated medical evidence at the hearing, instead issuing a decision denying benefits based on an incomplete medical record. This is not an outcome that anyone should welcome. It can definitely happen under these proposed rules because claimants must depend on the discretion of the ALJs to look at evidence which was obtained less than 20 days before the hearing. If that discretion is abused in certain cases, the claimant will not be able to appeal to anyone at the agency, but will have to file suit in the Federal District Court, where a judge will be asked to decide not whether the evidence proves disability, but whether the ALJ was wrong to refuse to consider the evidence. All of this will happen because of impractical and unworkable deadlines, which will result in decisions based on incomplete records that cannot be repaired, and which will lead to litigation which should not have been necessary

in the first place. We submit that such results are not only unfair to the claimants, but are also extremely inefficient and, thus, do not advance the Commissioner's goals.

Second, the new rules would prohibit an ALJ from reopening a prior decision based on new and material evidence showing that it was wrong. Under existing regulations, such reopening has never been required, and has happened only in certain cases. It has been used by ALJs to right obvious wrongs. In one recent case, one of our clients, Mrs. O, had back surgery with initial improvement, which the State agency used to deny her claim just after her insured status had expired. Fusion was attempted in a second operation only months later, but the State agency refused to consider her new application because her insured status had expired. Finally, because new evidence showed the fusion failed and a third surgery was required an ALJ appropriately reopened the earlier denial and awarded Mrs. O her benefits.

These proposed rules would have barred that ALJ from reopening the earlier determination and Mrs. O would have been forever barred from reapplying for the disability insurance benefits to which she was clearly entitled under the statute. This kind of harsh result is unthinkable under the rules that have been in place for decades. It would be inevitable under the new rules because the ALJ would have no choice in the matter. The prior decision could never be reopened no matter what new evidence was obtained. Finally, the proposed rules take away a claimant's right to appeal an ALJ decision within the agency. Under current regulations, the Appeals Council decides nearly 100,000 cases a year on average. Those 100,000 claimants will have no recourse other than filing lawsuits in the District Courts. Some will never find experienced counsel to file suit and will lose their right to appeal. Those who retain counsel could exponentially increase the number of Social Security cases filed in the courts.

Such a docket explosion would be unacceptable to the courts, but it is virtually certain to happen under the new rules. Indeed, since many of the new filers would have been expected to get relief from the Appeals Council, if it still existed, it is highly likely that they would obtain favorable decisions in the courts, leading to mountains of remanded cases at the ALJ level. In other words, while the Commissioner may believe she is reducing processing times by exporting a backlog of cases to the courts, she may ultimately be forced to re-import that backlog through court orders, thus defeating her original purpose. As laudable as the Commissioner's goals are, they will not be well served by these aspects of the proposed rules. We urge the Commissioner to make significant changes in the rules that will protect claimants' rights to decisions, that are not just vast, but are based on all the evidence, and, thus fair to claimants. Nothing less should be acceptable to this Congress or to the Commissioner. Thank you very much.

[The prepared statement of Mr. Sutton follows:]

Statement of Thomas D. Sutton, President, National Organization of Social Security Claimants' Representatives, Trevoze, Pennsylvania

Chairman McCreery, Chairman Herger, Representative Levin, Representative McDermott, and Members of the Social Security and Human Resources Subcommit-

tees, thank you for inviting NOSSCR to testify at today's hearing on the Commissioner's proposed regulations to improve the disability claims process.

My name is Thomas D. Sutton and I am the president of the National Organization of Social Security Claimants' Representatives (NOSSCR). Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability or Supplemental Security Income (SSI) benefits. NOSSCR members represent these individuals with disabilities in legal proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of more than 3,600 members from the private and public sectors and is committed to the highest quality legal representation for claimants. NOSSCR is a member of the Consortium for Citizens with Disabilities Social Security Task Force and we endorse the testimony presented today by Marty Ford on behalf of the Task Force.

I currently am an attorney in a small law firm in the Philadelphia, PA area. Adding to my experience in legal services programs, I have represented claimants in Social Security and SSI disability claims for the past 19 years. While I represent claimants from the initial application through the Federal court appellate process, the majority of my cases are hearings before Social Security Administrative Law Judges and appeals to the Social Security Administration's Appeals Council. This also is true for most NOSSCR members. In addition, I represent claimants in federal district court and in the circuit courts of appeals.

We agree with the Commissioner that reducing the backlog and processing time must be a high priority and we urge commitment of resources and personnel to reduce delays and to make the process work better for the public. We strongly support changes to the process so long as they do not affect the fairness of the procedures used to determine a claimant's entitlement to benefits. The Commissioner's July 27th notice of proposed rulemaking (NPRM), published at 70 Fed. Reg. 43590, does provide some positive changes. However, our overarching concern is that some aspects of the proposed process elevate speed of adjudication above accuracy of decisionmaking. From our perspective as advocates for claimants with disabilities, this is problematic and not appropriate for a nonadversarial process.

It is appropriate to deny benefits to an individual who is found not eligible, if that individual has received full and fair due process. It is not appropriate to deny benefits to an eligible individual simply because he or she has been caught in a procedural tangle. Especially vulnerable will be unrepresented claimants. There are serious concerns that claimants will be denied not because they are not disabled, but because they have not had an opportunity to present their case.

NOSSCR will provide detailed comments to the NPRM by the October 25th deadline. My testimony today will highlight our major concerns and provide some alternative approaches.

1. Improving the Process with New Technology and Early Development of the Evidence

Before addressing our specific reactions to the NPRM, I would like to address two issues, which are not part of the NPRM, that could significantly improve the decisionmaking process and decrease processing times.

First, Commissioner Barnhart has announced major technological initiatives to improve the disability claims process, which NOSSCR generally supports. In several states, SSA has begun to process some disability claims electronically. This initiative has the prospect of significantly reducing delays by eliminating lost files, reducing the time that files spend in transit, and preventing misfiled evidence. Claimants' representatives are able to obtain a single CD that contains all of the evidence in the file. We want to thank the Commissioner for her inclusive process to seek comments about these changes, which will help to ensure that claimants benefit from these important improvements. We have had several very productive meetings and we appreciate this valuable opportunity to provide input.

Second, there should be better development of the record at the beginning of the claim so that the correct decision can be made at the earliest point possible. Claimants should be encouraged to submit evidence as early as possible. The benefit is obvious: the earlier a claim is adequately developed, the sooner it can be approved. However, based on my own experience and that of other NOSSCR members, critical pieces of evidence are missing when claimants first come to me for representation and it is necessary for representatives to obtain this evidence.

Recommendations to improve the development of evidence include: (1) SSA should explain to the claimant in writing, at the beginning of the process, what evidence is important and necessary; (2) DDSs need to obtain necessary and relevant evidence, especially from treating sources, including non-physician sources (therapists, social workers) who see the claimant more frequently than the treating doctor and

have a more thorough knowledge of the claimant; (3) Improve provider response rates to requests for records, including more appropriate reimbursement rates for medical records and reports; and (4) Provide better explanations to medical providers, in particular treating sources, about the disability standard and ask for evidence relevant to the standard.

II. Reviewing Official

This is the first administrative appeal in the proposed process. In performing his or her job, the Reviewing Official (RO) is caught between the DDS and the Federal Expert Unit (FEU). In previous testimony, we have supported elimination of the reconsideration appeal level. SSA has tested the elimination of reconsideration in ten “prototype” states for several years, including Pennsylvania where I practice. Our members in those states report that the process works well without a review level between the initial determination and the ALJ level.

If there is a Reviewing Official, we support the use of attorneys to be ROs and who are, as discussed in the NPRM preface, “highly qualified” and “thoroughly trained” in SSA policies and procedures. However, the RO’s authority must be clarified. Under the NPRM, the RO must “consult” with the FEU if a claimant submits new and material evidence. If the RO disagrees with the DDS denial, the FEU must “evaluate” the evidence. Is the decisionmaker really the RO or the FEU? The final rule must establish that the RO, and not the FEU, is the final arbiter.

Another concern is that under the NPRM, the claimant is only allowed to submit new evidence with the request for review. After that point, only the RO can obtain new evidence and the RO could refuse to consider new evidence.

Recommendation. To ensure fairness and a complete record, we recommend that the claimant be allowed to submit new evidence as it becomes available up to the date that the RO issues the decision.

III. Administrative Law Judge

The NPRM includes some provisions that benefit claimants including retaining the *de novo* hearing before an administrative law judge (ALJ) and, for the first time, setting a goal (but not requirement) that the hearing be held within 90 days after the appeal is filed. Also, the time for providing notice of the hearing date is increased from 20 to 45 days. However, there are a number of procedural changes that are disadvantageous to claimants. The proposed rule creates strict limits and procedures for submission of new and material evidence. For many claimants who meet the statutory definition of disability, the result could well be a denial based on an incomplete record.

Duty to submit evidence twenty days before the hearing. The NPRM requires that a claimant submit evidence at least 20 days before a hearing, with very limited exceptions. It is in the ALJ’s discretion to accept or reject evidence submitted less than 20 days before the hearing; no standards are set out for this decision. The preface does not claim that this evidence is somehow less valuable or probative in determining disability; instead it states that “late submission” of evidence “significantly impedes our ability to issue hearing decisions in a timelier manner” and “reduces the efficiency of the hearing process because we often must reschedule.”

Closing the record before the hearing is inconsistent with the Social Security Act. The Act provides the claimant with the right to a hearing with a decision based on “evidence adduced at the hearing.” 42 U.S.C. § 405(b)(1). The current regulations reflect the statute, providing that “at the hearing” the claimant may submit new evidence. 20 C.F.R. § 404.929. A previous proposal to set a due date for submission of evidence was abandoned by SSA because it appeared to close the record in contravention of the statute. See 68 Fed. Reg. 41411–12 (Aug. 4, 1998) (final rule on Rules of conduct and standards of responsibility for representatives, codified at 20 C.F.R. § 404.1740).

In addition to this statutory requirement, there are many practical and fairness reasons why the record should not be closed. Are these administrative efficiency goals more important than developing a full and complete record of evidence for the claimant? What about case law in every Circuit holding that ALJs have a duty to develop the evidence? What about a claimant who seeks representation fewer than 20 days before the hearing? Based on my own experience and that of other NOSSCR members, this is not an uncommon occurrence since the ALJ hearing is the claimant’s first in-person contact with an adjudicator (this would not change under the NPRM). The ALJ is required to explain the right to representation and postpone the hearing if an unrepresented claimant wishes to seek a legal representative. Under the NPRM, how would this situation affect the requirement that a claimant

submit evidence within 20 days of the hearing, given the fact that representatives play a key role in obtaining evidence?

We strongly support the submission of evidence as early as possible, since it means that a correct decision can be made at the earliest point possible. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record will not help claimants, including: (1) worsening or clarified diagnosis of the medical condition which forms the basis of the claim; (2) factors outside the claimant's control, such as beleaguered or uncooperative medical sources who simply do not respond promptly to requests for records; and (3) the need to keep the process informal.

In the vast majority of cases, there are justifiable reasons why evidence is not submitted earlier in the process. However, we do not support the withholding of evidence by representatives. If an ALJ believes that a representative has acted contrary to the interests of the client/claimant, remedies other than closing the record, which would only penalize the claimant, exist to address the representative's actions. For instance, as discussed below, the current Rules of Conduct already require representatives to submit evidence "as soon as practicable" and to act with "reasonable diligence and promptness" and establish a procedure for handling complaints.¹

Submission of evidence after the hearing. After the ALJ decision, opportunities to submit new evidence are even more limited under the NPRM, with narrow exceptions and procedural hurdles to overcome. A request to submit must be made within 10 days after receiving the ALJ decision. Unless the claimant can show that there was an unforeseen and material change, the claimant must first ask the ALJ at the hearing to keep the record open. The ALJ is under no obligation to grant the request. If the ALJ does not grant the request, the claimant cannot submit the evidence. Even if the ALJ keeps the record open, the claimant must show good cause for missing the deadline. The ALJ has the discretion to find that there was no good cause.

Under the current process, "new and material evidence" can be submitted with an appeal to the Appeals Council. 20 C.F.R. §§ 404.970(b) and 404.976(b). But since the claimant's right to request review of an unfavorable ALJ decision is eliminated in the NPRM, the opportunity to submit newly obtained evidence after the hearing evaporates.

Contrary to assertions by some that there is an unlimited ability to submit new evidence after the ALJ hearing, the current regulations and statute are very specific in limiting that ability at later levels of appeal. At the Appeals Council level, new evidence will be considered, but *only* if it relates to the period before the ALJ decision and is "new and material."² At the federal court level, the record is closed and the court will not *consider* new evidence. The court does have the authority to remand the case for SSA to consider the additional evidence, but only if the new evidence is (1) "new" and (2) "material" and (3) there is "good cause" for the failure to submit it in the prior administrative proceedings.³

Recommendations. We offer the following recommendations for the submission of new evidence:

- **More notice of the hearing.** Any prospect of improvement with the proposed 45-day notice is essentially negated because of the requirement to submit evidence 20 days before the hearing. While a full 45 days (without a 20-day pre-hearing time limit to submit evidence) would be acceptable, a 60-day or even 90-day notice requirement would significantly improve the ability to obtain and timely submit evidence.
- **No time limit to submit evidence before the hearing.** This is consistent with the claimant's statutory right that a decision be based on evidence "adduced at a hearing." The current rule, which allows evidence to be submitted until the hearing, should be retained.
- **Submission of post-hearing evidence.** If the record is closed after the hearing, there should be a good cause exception that allows a claimant to submit new and material evidence after the hearing.
- **Early and easy access to the exhibit file.** This allows the representative to promptly review what is already in the record and to determine what other

¹ 20 C.F.R. §§ 404.1740 and 416.1540. In a 1999 letter report to Rep. E. Clay Shaw, Jr., when he was chairman of the Social Security Subcommittee, and to Rep. Mac Collins, the Government Accountability Office found that SSA does have tools to deter delay, including reducing representatives' fees or use of the Rules of Conduct. *Social Security: Review of Disability Representatives*, GAO/HEHS-99-50R (Mar. 4, 1999).

² 20 C.F.R. §§ 404.970(b) and 416.1470(b).

³ 42 U.S.C. § 405(g).

medical evidence needs to be obtained. We believe that this part of the process will be vastly improved with the implementation of eDIB, the electronic folder.

- **Do not penalize claimants for circumstances outside their control.** While this applies to difficulties in obtaining evidence, it also can apply if representatives act in a way contrary to the interests of the client/claimant. ALJs can use the regulatory rules of conduct for representatives. Claimants should not be penalized.

Duty to submit all “available” evidence, both favorable and unfavorable to the disability claim. The NPRM requires the claimant to submit all evidence “available to you.” This includes “evidence that you consider to be unfavorable to your claim.” The preface clarifies that this includes adverse evidence, i.e., evidence that “might undermine” or “appear contrary” to the claimant’s allegations.

The claimant is required to disclose material facts in his or her claim for benefits. However, the proposed regulation could very well set a trap for unsuspecting claimants. What is meant by “available”? Only that evidence which has been obtained or all evidence that exists, regardless of the cost, time, or effort? What is meant by evidence you “consider” to be unfavorable? Is this too subjective? Who makes the decision that evidence is “available”? Would a claimant be penalized if an adjudicator decided that there was noncompliance? Does this requirement place an undue burden on claimants with mental or cognitive impairments?

Another concern is that this proposed requirement could open the process to manipulation by those who have a personal grudge against the claimant or interests adverse to the claimant, e.g., former spouses, creditors, insurance companies.

For attorney representatives, we have serious concerns that this requirement may conflict with state bar ethics rules which limit the submission of evidence that could be considered adverse to a client. This proposed requirement seems to misunderstand the general duties and obligations of attorneys. In every state, attorney representatives are currently bound by state bar rules that forbid an attorney from engaging in professional conduct involving dishonesty, fraud, deceit, or willful misrepresentation. An attorney who violates this rule is subject to disciplinary proceedings and possible sanction by the state bar. Existing bar rules in every state also require an attorney to zealously advocate on behalf of a client. An attorney who violates this rule is also subject to sanction by the state bar.

Recommendation. We recommend that SSA continue to use the current regulations regarding the duty of claimants and representatives to submit evidence. In the experience of our members, these regulations have worked well, especially when combined with the duty to inform SSA of all treatment received.

Other issues at the ALJ hearing level

1. Issues to be decided by the ALJ. The NPRM requires that the claimant “must” state the specific reasons why he or she disagrees with the RO’s decision when the hearing request is filed. Proposed § 405.310(a)(3). In contrast, the proposed rule for requesting RO review of the initial denial states that the claimant “should” provide the reasons. Proposed § 405.210(a)(3). Likewise, the current regulation also uses “should” rather than “must” in this context. 20 C.F.R. § 404.933(a)(2).

Issues often emerge or become clearer as the hearing process evolves, for instance, as additional evidence is obtained and submitted or when representation is obtained. Claimants should not be tied down to issues listed at the time of their appeal. In addition, this requirement would be extremely problematic for unrepresented claimants who cannot be expected to know the details of SSA policies and procedures. And what would happen if a claimant who is unrepresented at the time the hearing request is filed obtains legal representation later in the process? Would the representative be precluded by the ALJ from raising additional issues?

Recommendation. Retain the current regulation language that states a claimant “should,” but not “must,” provide specific areas of disagreement at the time the request for hearing is filed.

2. Objecting to issues in hearing notice. The NPRM requires that the claimant object to issues in the hearing notice within 10 days of receiving the notice. Proposed § 405.317(b). There is no opportunity to extend this time limit. The current regulation provides flexibility, stating that the objections should be raised “at the earliest possible opportunity.” 20 C.F.R. § 404.939. As discussed above, what if the claimant obtains legal representation more than 10 days after receiving the hearing notice? Is the representative precluded from raising issues? This would seem to be inconsistent with due process.

Recommendation. Retain the current regulation language that encourages claimants to object to issues in the hearing notice “at the earliest possible opportunity.”

IV. Decision Review Board

Under the proposal, claimants will no longer have access to a final administrative appeal step. Their only recourse is to file a complaint in federal district court.

In contrast, the DRB can select any ALJ decision for review. The DRB can affirm, reverse, or modify an ALJ decision, whether favorable or unfavorable, if there is an error of law. But if there is a factual error, the DRB must remand to the ALJ. If the DRB reverses a claimant-favorable ALJ decision, that claimant must proceed to federal court to fight for the benefits awarded by the ALJ. We are concerned that if claimants have no right to request review, the agency may revert to reviewing a significantly higher number of favorable ALJ decisions, despite the initial well-intended goal of reviewing an equal share of favorable and unfavorable ALJ decisions.

Currently, the Appeals Council provides effective relief to claimants. Over 25% of claimants who request review either receive benefits outright or receive another chance for an ALJ hearing if the case is remanded. The process is much more simple than filing a federal court case and has no cost. The claimant can submit new and material evidence, a critical factor if they were unrepresented at the ALJ hearing level. The Appeals Council also reviews ALJ dismissals and reopening denials; allegations of unfair ALJ hearings; and both disability and nondisability issues that arise in the same case.

Claimants and their representatives have a very limited role at the DRB. If the DRB selects a case, a notice will be included along with the ALJ decision. To submit new evidence to the DRB, the same strict post-ALJ decision submission requirements apply. The DRB may “invite” a brief. Unless the DRB extends this invitation, the claimant must ask permission within ten days of receipt of the Review Notice to submit a brief. And if permission is granted, the brief may not exceed three pages, regardless of the case’s complexity. The proposed regulation provides, “If you file a written statement in a claim and the Board has not asked or allowed you to submit one, the Board will not consider the written statement and will return it to you without making it a part of the record.” Proposed § 405.425(b)(2). Such strict limitations could be viewed the same as denying the right to present arguments at all.

Selection of cases for DRB review. The ALJs will now be caught between the RO and the DRB. Their decisions must explain why they are not following the denial decision of the RO. And they will be aware that every single decision they issue for every disability claimant will be screened by the DRB, or at least by computer-based predictive screening tools. SSA will develop a profile of decisions that are most likely to be “error prone.” It seems possible that ALJs will quickly learn which case characteristics are most likely to trigger DRB review. Will they be the nature of the impairment? The age of the claimant? A residual functional capacity finding of “less than-sedentary”? A credibility finding of fully credible?

The DRB has a 90-day window in which to act on a case selected for review (if a case is there for more than 90-days, an aggrieved claimant may proceed directly into court without a DRB decision). The 90-day time limit runs from the date that the notice of DRB review is received by the claimant. However, after the ALJ issues a decision, there is no time limit for the DRB to screen and select the case for review. The claimant will only receive the ALJ decision after the screening has occurred. This process could present possible conflicts with a provision in the Social Security Act, 42 U.S.C. § 423(h), which requires that interim benefits be paid if the Commissioner’s “final decision” is not issued within 110 days after a favorable ALJ decision.

The impact of the DRB on the federal courts. Aware of the concerns that the elimination of the Appeals Council will produce an avalanche of cases descending on the federal district courts, the NPRM has proposed a gradual implementation, beginning with one small region. During this implementation, the agency plans to monitor the number of federal court filings in that region. It is not clear what decision the agency will make, based on the number. If the federal court filings escalate significantly, is the agency prepared to reinstate a final administrative level of review accessible by claimants? Or would the agency seek legislation to create a Social Security Court to provide relief to the federal district courts?

What will federal judges say about new evidence which is submitted to the court but which had not been accepted by the agency adjudicators? Under the Social Security Act, 42 U.S.C. § 405(g), the court may order that SSA take additional evidence if there is a showing that the evidence is new and material and there is good cause for the failure to “incorporate such evidence into the record” in the prior administrative proceeding. As discussed earlier, how will the strict rules on submission of evidence affect the courts? Will claimants be forced to file an appeal in district court to have SSA consider evidence that should have been considered during the admin-

istrative process? Will district court appeals increase dramatically simply for this reason?

SSA has previously tested the elimination of claimant-initiated Appeals Council review in the same “prototype” states where it tested the elimination of the reconsideration level. Although requested, we have been unable to obtain information about the results of the Appeals Council prototype testing. Further, we have concerns that the NPRM’s gradual implementation of this change with unspecified future changes to meet undefined problems may be inconsistent with the requirements of rulemaking under the Administrative Procedures Act, 5 U.S.C. § 553. Given the potential impact of eliminating claimant-initiated Appeals Council review on the federal courts and on claimants, we recommend that it would be more appropriate to conduct a “test” under the Commissioner’s demonstration authority rather than through final regulations.

Claimant appeals of ALJ dismissals. The only claimant-initiated review at the DRB is where the ALJ has dismissed a request for hearing, representing a significant percentage of unfavorable ALJ decisions. Often, these decisions are legally erroneous and currently the Appeals Council is able to review and remand the cases so that the substantive disability issues can be considered. We appreciate the fact that a claimant can appeal an ALJ dismissal to the DRB; however, even this appeal is subject to numerous procedural hurdles: the claimant must first ask the ALJ to vacate the dismissal within 10 days after the ALJ decision is received, with no extension of time (although the ALJ has no time limit to decide the request to vacate); any written statement to the DRB must be filed with the request for DRB review and is limited to 3 pages, regardless of the complexity of the case or additional supportive evidence. The reason that providing DRB review is critical is that hearing dismissals generally cannot be appealed to court.

Recommendations:

- The claimant’s right to request administrative review of an unfavorable ALJ decision should be retained.
- Before eliminating the claimant’s right to request review by the Appeals Council, SSA should test elimination of administrative review of ALJ decisions under the Commissioner’s demonstration authority.
- Reasonable rules for procedures before the DRB should be established.
- The current rules for submission of new evidence to the Appeals Council should be retained—it must be “new,” “material,” and relate to the period before the date of the ALJ decision.
- There should be no page limit for written statements but claimants and representatives should be encouraged to keep them brief and succinct.
- There should be no requirement that hearing dismissals first be presented to the ALJ. If that requirement is retained, there should be a time limit for the ALJ to decide the request.
- The 90-day time limit should run from the date of the ALJ decision, rather than the date of the DRB’s notice.

V. Reopening

Reopening situations currently do not arise that often, but when they do, they usually have compelling fact patterns involving claimants who did not understand the importance of appealing an unfavorable decision. Often they are claimants with mental impairments.

Most reopening determinations currently are discretionary; SSA proposes to take away even that. Reopening within one year for “any reason” is eliminated. New and material evidence is no longer good cause for reopening and is specifically precluded in proposed § 405.605(c)(2). Under the NPRM, reopening is allowed in only two situations: clerical error in computation of benefits or clear error on the face of the evidence. Reopening can happen only within six months of the final action on a claim, but not based on new and material evidence.

The result will be a loss of benefits and perhaps a total loss of eligibility, if the “date last insured” status has expired. This is unfair for claimants in a number of situations, such as: claimants who are not able to get a proper diagnosis for a considerable period of time (multiple sclerosis, for example); claimants whose cases were poorly developed at the DDS and were not appealed and who then filed new applications; claimants with mental impairments that prevent or inhibit their ability to cooperate with development of claims; cases where physicians refuse to provide medical records until unpaid bills are paid; and bankrupt hospitals who are unable to provide records.

According to the NPRM preface, the reason for this change is to improve the timeliness of the administrative review process. However, it is not clear how this dra-

matic change would improve the process, from a claimant's perspective. In my experience and that of other NOSSCR members, reopening requests have not delayed decisions. The proposed change completely eliminates ALJ discretion to reopen an earlier decision where new and material evidence shows that the claimant was disabled at an earlier time. The proposal also exacerbates the adverse impact of the strict rules for submission of evidence.

Why reapplying is not an option. The NPRM preface states that if the claimant cannot submit new evidence, he or she can file a new application. As noted in Marty Ford's testimony on behalf of the CCD Social Security Task Force, this statement is not accurate and may permanently foreclose eligibility if the claimant's insured status has expired. Congress has previously addressed the problem of SSA informing claimants that they could reapply rather than appeal and failing to inform them of the consequences. In the past, SSA's notices misled claimants regarding the consequences of reapplying for benefits in lieu of appealing an adverse decision and Congress responded by addressing this serious problem. Since legislation enacted in 1990, SSA has been required to include clear and specific language in its notices describing the possible adverse effect on eligibility to receive payments by choosing to reapply in lieu of requesting review.⁴

Recommendation. The current reopening rules work well and do not affect the timeliness of decisions and they should be retained. It is vitally important that claimants have a fair and reasonable ability to have new and material evidence considered.

CONCLUSION

For people with disabilities, it is critical that the Social Security Administration address and significantly improve the process for determining disability and the process for appeals. We strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as they do not affect the fairness of the process to determine a claimant's entitlement to benefits.

Unfortunately, several aspects of the proposed regulations will damage the rights of claimants to have their cases fully considered, and will result in denials of benefits to claimants who meet the statutory definition of disability but who cannot comply with the harsh rules and strict time limits of these rules. We urge the Subcommittees to work with the Commissioner to amend the proposed regulations so that the rights of claimants are fully protected, even as decisions are made in a more efficient and timely manner.

Thank you for this opportunity to testify before the Subcommittees on issues of critical importance to claimants. I would be glad to answer any questions that you have.

Chairman HERGER. Thank you. Dr. Bloch to testify.

STATEMENT OF FRANK S. BLOCH, PH.D., PROFESSOR OF LAW, VANDERBILT UNIVERSITY SCHOOL OF LAW, NASHVILLE, TENNESSEE

Mr. BLOCH. Thank you, Mr. Chairman. I also appreciate the opportunity to express my views on the Social Security Commissioner's proposed rules on the disability determination process before the two Subcommittees today. I have studied, taught about, written on, and actually worked with the Social Security disability determination process for most of my professional life. I applaud the Commissioner's initiative in seeking the reform that she proposes to this critically important administrative apparatus. The need for disability determination process reform is clear, and it has been for many years. As Judge McDonald just noted, efforts have been introduced to try to change this process over the past years, and it has proved to be difficult, and we have seen many failed efforts at reform. I agree that the new rules we are examining today may finally break that pattern and see the light of day and that

⁴ 42 U.S.C. §§ 405(b)(3) and 1383(c)(1).

makes it all the more important that they be examined carefully and critically at this time.

Much of what the Commissioner has proposed would improve the process. For example, I agree with her plan to eliminate the reconsideration level of review. This can help focus resources and energy for disability determination at the two critical points in the process—the initial administrative decision and the ALJ hearing. Her plan to implement quick disability determinations at the initial decision level is also a positive and practical approach to case management. The proposal to eliminate the Appeals Council is a little more complicated. It may result in unnecessary appeals to Federal court, as has been said. It may also result more distressingly in the fact that ALJ decisions may never be reviewed at all where the claimant does not have the means to proceed to court. I would like to concentrate my remarks on two aspects of the proposed disability determination process that I think may undercut the effectiveness of the reforms.

Those are the specific roles ascribed to the new RO position and the various rules on submitting evidence and closing the record at the ALJ decision level. In my written remarks, I talk about these in detail and propose some recommendations. Let me now just highlight a few of those points. With respect to the RO position, I believe that the process would be better served by really eliminating reconsideration rather than by substituting another mid-level decisionmaker in its place. In many respects, the RO position, in my view, is simply another method of reconsideration. What we need at this stage is someone who could review the initial decision and the record on which it is based, assume some active responsibility for preparing the claim for the next step in the process, which is the full-blown administrative hearing and decision by an independent ALJ. Both claimant and SSA interests could be served better by charging the new RO with the responsibility to assure the development of a timely, full, and fair record.

Reviewing officials would be in an ideal position to frame issues on appeal, to seek out specific additional medical and vocational information needed to evaluate the claim under the applicable rules and regulations, and to grant claims on the record perhaps all as part of a process still focused on two primary decision points—the initial decision and the ALJ hearing. This could be done along the lines that were suggested in a report that I prepared, together with Jeffrey Lubbers and Paul Verkuil for the Social Security Advisory Board a few years ago, in which we included a recommendation for a position we called counselor, who would have the express mandate of overseeing and facilitating the development of the evidentiary record between the initial decision and the ALJ hearing. That report is referenced and some of those recommendations are included in my written testimony. The key point in our recommendation was that the SSA should concentrate its efforts on improving the record for decision at the ALJ hearing. That is the critical point in the process, and I suggest that the new disability determination process would be served better if the RO sort of had that kind of role rather than the decisionmaking role that the RO now has.

With respect to submitting evidence in the ALJ hearing and closing the record, it has been pointed out that this is a radical departure under current practice. With all respect to the Commissioner's response to the question as to what the reason for it is, I am not convinced that there is a good reason for this radical departure. Records are closed at some point in order to allow the decision-maker, in this case the ALJ, to make a proper decision. The Commissioner's proposal does authorize the ALJ to have a pre-hearing statement requested and that, together with the development of the record, by someone like the RO, counselor that I described earlier, could achieve that point. The idea is that the ALJ should receive the record necessary to make a prompt and accurate decision. The process should not cut the all important record development function off at the pass.

More importantly, or most importantly, this is a—these complex set of rules are a potential devastating trap for claimants. Even claimant lawyers will have a hard time keeping track of and managing these time limits. For unrepresented claimants, it will be all but impossible. Again, the report that I had mentioned in my written remarks to the Social Security Advisory Board proposes that the evidentiary record could be closed at the hearing subject to the ability to reopen the hearing if there is new and material evidence and good cause for failing to produce that evidence at the hearing. I suggest that the Commissioner's proposed rules on submitting evidence and closing the record should be scrapped altogether and replaced with a simple statement that the record can be closed by the ALJ at some time after the hearing, subject to exceptions for new and material evidence and a good cause for failure to produce those at the time of the hearing. Thank you.

[The prepared statement of Mr. Bloch follows:]

**Statement of Frank S. Bloch, Ph.D., Professor of Law, Vanderbilt
University School of Law, Nashville, Tennessee**

Chairman McCreery and Chairman Herger, Representatives Levin and McDermott, and other Members of the Subcommittees:

I appreciate this opportunity to express my views on the Social Security Commissioner's proposals concerning the disability determination process that were published this summer as a Notice of Proposed Rulemaking (Administrative Review Process for Adjudicating Initial Disability Claims, 70 Fed. Reg. 43590 July 27, 2005). I have studied, taught about, written on, and worked with the Social Security disability determination process for most of my professional life, and I applaud the Commissioner's initiative in seeking to reform this critically important administrative apparatus.

The need to reform the disability determination process is clear, and has been for many years. It is difficult enough to decide whether any one individual is unable to engage in "substantial gainful activity" in light of not only his or her physical and mental impairments, but also any effects of age, education, and prior work experience. Making disability determinations fairly and accurately for millions of claims (and in hundreds of thousands of appeals) is an all but overwhelming task. Unfortunately, efforts to introduce fundamental changes in the disability determination process have proven to be even more difficult, as seen by the long record of failed reform proposals over the past twenty-five years. The new rules we are examining today may finally break that pattern and see the light of day, which makes it all the more important that they be examined carefully and critically.

The concerns expressed most often by SSA and others about the current disability decision process are the amount of time taken to reach final decisions and a lack of confidence in the accuracy and consistency of the decisions themselves. I believe that one fundamental, intractable problem lies at the root of these concerns: throughout the process, decisionmakers—including ALJs following a full administrative hearing—often make disability determinations on the basis of incomplete evi-

dentiary records. In my opinion, any effort to reform the disability determination process must target the prompt development of a full and complete record. Unless that critical part of the process is fixed, decisionmakers—no matter what they are called or under what new set of rules they operate—will not be able to do their job.

This position was reinforced a few years ago when I participated in a study for the Social Security Advisory Board that looked into the possibility of introducing government representation at Social Security hearings and the question of when and how to close the administrative record. (See *Introducing Nonadversarial Government Representatives to Improve the Record for Decision in Social Security Disability Hearings* (June 11, 2003), available at <http://www.ssab.gov/blochlubbersverkuil.pdf>. The study was also reported on in an article based on the SSAB report. See Frank S. Bloch, Jeffrey S. Lubbers & Paul R. Verkuil, *Developing a Full and Fair Evidentiary Record in a Nonadversarial Setting: Two Proposals for Improving Social Security Disability Adjudications*, 25 *Cardozo L. Rev.* 1 (2003).) During the course of the study, we had the opportunity to interview the full range of interested parties, including front line SSA and state agency (DDS) personnel, ALJs, and claimant advocates. In order to frame the issues, we asked supporters of government representation to explain what they thought a government representative (or someone in another, similar role) would add to the process from a functional perspective. Interestingly, virtually all of them pointed to the need for better development of the evidentiary record. Similarly, differences in views about closing the record among the people we interviewed depended to a large extent on the person's confidence about the record development process. Those who were the most confident about the record development process were more likely to suggest a "bright line" cut-off; those more concerned about the quality of the record, even after an ALJ hearing had been held, were more likely to suggest some sort of safety valve—such as a "good cause" requirement for submitting additional evidence along the lines of the requirement for submitting additional evidence at the district court.

If the key problem is an often-incomplete record, the question becomes how to overcome that problem. Really, there are two distinctly different aspects of the incomplete record problem. One has to do with the length of the current process and the nature of the claimant population. With sometimes literally years passing as a claimant works his or her way through the various stages of the current process (initial decision, reconsiderations, ALJ hearing, and Appeals Council review), medical conditions change. Therefore, even accurate evidentiary records will look different at different stages of the process. The other aspect results from deficiencies in the design and implementation of the process itself. Staff charged with processing disability claims—particularly at the state DDS, but also at the Office of Hearings and Appeals—are neither trained properly nor given the resources necessary to compile the specific detailed medical information necessary to determine disability under SSA rules and regulations.

Much of what has been proposed by the Commissioner would improve the process and result in better records for decision. Thus, I agree with the Commissioner's plan to eliminate the reconsideration level of review. Simply shortening the process will reduce the "moving target" problem of claimants' changing medical conditions. More fundamentally, this can help focus resources and energy for disability determination at the two critical, yet fundamentally different, decision points in the process: the initial administrative decision, and the ALJ hearing. The current model dissipates limited resources and energy for disability determination by spreading the process over four administrative levels—particularly the essentially repetitive initial decision and reconsideration levels.

The Commissioner's plan to implement "Quick Disability Determinations" at the initial decision level for selected types of claims is a positive and practical approach to case management. The effort to improve the quality and uniformity of medical expert input through a Federal Expert Unit is another welcome innovation. The proposal to eliminate Appeals Council review is more complicated, as it removes the possibility of administrative review of many ALJ decisions that may result in unnecessarily appeals to federal district court—or, more distressingly, may well lead to many ALJ decisions not being reviewed at all where the claimant does not have the means to proceed to court. But it does have the advantage, as with the elimination of reconsideration, of focusing the disability determination process on initial decisions and ALJ hearings and moving the process along. And it introduces a potentially effective mechanism for quality control by focusing specifically on that function.

There are, however, two aspects of the proposed disability determination process that are problematic and may undermine the effectiveness of the reforms: the role set out for the "Reviewing Official" and the complex set of rules on submitting evidence and closing the record at the ALJ hearing. The new Reviewing Official posi-

tion—placed in the process as a potentially powerful decisionmaker between the initial decision level and the ALJ hearing—has not been thought out carefully. As I will explain more fully in a moment, there are good reasons to allocate additional resources between the initial decision and the ALJ hearing. Unfortunately, the Commissioner's approach to the role of the Reviewing Official misses the mark. The effort here should be to bolster and support the ALJ hearing as the single administrative appeal; instead, the new Reviewing Official looks more like some form of modified reconsideration. The rules on submitting evidence and closing the administrative record at the ALJ hearing are aimed at supporting ALJs in their critically important independent decisionmaking role. Closing the record in time for the ALJ to reach a careful decision is a laudable goal if implemented together with serious efforts at developing a full and complete evidentiary record. The result sought can be achieved quite simply; however, once again these parts of the Commissioner's proposal have not been thought out carefully. The complex set of proposed rules has no coherent justification or rationale and is potentially disastrous for claimants.

I will now discuss each of these aspects of the proposed rules in detail, followed by recommendations for revising them.

Role of the Reviewing Official

In my opinion, the Reviewing Official's role in the Commissioner's new disability determination process is both too limited and too large. I believe that the process would be better served by really eliminating reconsideration, rather than by substituting another mid-level decisionmaker in its place. The question then becomes: what should be done in order to assure that a direct appeal from initial decision to ALJ hearing will improve the overall disability determination process?

What is needed at this stage is someone who could review the initial decision and the record on which it was based, and assume active responsibility for preparing the claim for the next step in the process: a full blown administrative hearing and decision by an independent ALJ. This would include evaluating the initial decision and the medical evidence in the record, obtaining additional evidence if needed, and, in appropriate cases, proposing to the ALJ that the claim be granted on the record without a hearing. Instead, the proposed rules would have a lawyer Reviewing Official act as a sort of pre-judge—making a new decision on the claim. Reviewing Official decisions would have all the trappings of a formal decision, written by a lawyer in a presumably lawyer-like style. Moreover, a lawyer Reviewing Official with full decision making authority could have a potentially more influential role in the overall process than the abandoned reconsideration decision. Although ALJs would not be bound formally in any way by the Reviewing Official decision, they might well be more inclined to defer to Reviewing Official decisions than a second administrative decision at reconsideration. But claimants and their representatives would have no more access to the Reviewing Official than they have now to the DDS reconsideration team.

Most of the all-important record development work on a Social Security disability claim—obtaining existing medical and vocational records, measuring existing information against alleged impairments and applicable eligibility criteria, ordering additional medical and/or vocational evaluations—are essentially neutral tasks that entail objective analysis that can be done best outside an adjudication type setting. Both claimant and SSA interests could be served better by charging the new Reviewing Official with the responsibility to assure the development of a timely, full, and fair record. Other tasks assigned to the Reviewing Official under the Commissioner's proposal—or, to some extent, to the ALJ—would remain appropriate for the Reviewing Official under this different model. Thus, Reviewing Officials would be in an ideal position to frame the issues on appeal, seek out specific additional medical or vocational information needed to evaluate the claim under applicable rules and regulations, and to grant claims on the record—all as part of a process still focused on two primary decision points, the initial decision and the ALJ hearing.

A number of proposals have been advanced over the years to address the record development problem in the disability determination process. Some have focused on existing administrative practices and procedures while others have suggested deployment or redeployment of personnel—all with the idea of improving SSA's performance relative to developing the record for decision. One of these in particular, the SSA's Senior Attorney Project, introduced a position at the Office of Hearings and Appeals that was charged with a role similar to the one outlined above for the new Reviewing Official. Fifteen years ago, the Administrative Conference of the United States (ACUS) recommended expanded use of prehearing conferences to frame the issues involved in the ALJ hearing, identify matters not in dispute, determine whether subpoenas might be necessary consider witnesses that might need to be called, and also decide appropriate cases favorable without hearings. (ACUS Rec-

ommendation 90–4, *Social Security Disability Program Appeals Process: Supplementary Recommendation*, 55 Fed. Reg. 34,213 (Aug. 22, 1990), at ¶¶ 2–3.) The Reviewing Official could orchestrate all of these functions in advance of the ALJ hearing with the cooperation of the DDS and with the participation of the ALJ, as appropriate.

The bridge between the initial decision and the ALJ hearing should be staffed by an administrator-facilitator whose role would be to support the ALJ hearing as the single independent administrative appeal. This could be done along the lines we suggested in the SSAB report referred to earlier, which included the following recommendation for a position we called a “Counselor”:

Recommendation 3: SSA should consider creating a new administrative position, called a “Counselor,” with the express mandate of overseeing and facilitating the development of the evidentiary record for decision. As part of this process, the Counselor position should have the following characteristics and responsibilities:

- It should be charged with developing a full and complete record as quickly as possible, in cooperation with claimants (and their representatives), DDS, OHA, and other SSA personnel.
- It should have direct access to key DDS personnel in order to question and clarify the DDS’s rationale for its disability decisions.
- It should have independent authority to obtain information for the record, including access to any available funds and enforcement mechanisms.
- It should have a formal role, either independently or in cooperation with ALJs and other OHA staff, to narrow and resolve particular issues and, when appropriate, to recommend to an ALJ a fully favorable, on-the-record decision.
- It should be designated nonadversarial, even if attorneys fill some of the positions.

The key to our recommendation was that SSA concentrate its efforts on improving the record for decision at ALJ hearings. We believed that the best way to achieve this goal was to introduce a nonadversary Counselor into the disability adjudication process whose central role would be to monitor the process of developing the evidentiary record and to work closely with all of the key actors—the claimant (and the claimant’s representative, if there is one), the ALJ, and SSA (most likely through DDS)—in order to identify any gaps in the record and to fill them as quickly and efficiently as possible. These Counselors would remove much of the development work from the ALJ, including the second- and third-hat roles of assuring that the claimant’s and SSA’s (or DDS’s) positions are fully supported, and would serve a much-needed administrative liaison function between the DDS and OHA. We also recommended that the Counselors be given the resources and authority necessary to develop records and move claims quickly, especially in those cases where benefits could be granted without a full administrative hearing.

I suggest that the Commissioner’s new disability determination process would be served better with Reviewing Officials/Counselors taking on this type of role, leaving full adjudication of appeals from agency initial decisions to independent ALJs.

Rules for Submitting Evidence at the ALJ Hearing and Closing the Record

The concept of “closing” a record arises in two very different contexts: preparing a record for decision and preserving the record of a decision for further administrative or judicial review. The process of preparing a record for decision usually continues until the decision is reached; the record is closed at the time (or just before) the decision is made. This is what happens at the initial decision and reconsideration in the current process and would continue at the initial decision and Reviewing Official stages under the proposed rules. The DDS is charged with developing the record to the point that a competent initial disability decision can be made. Then, only once the evidentiary record is complete, does the DDS make its decision based on the record it compiled. Presumably the same would be the case with the Reviewing Official; as at the DDS, the Reviewing Official would supplement the record as needed before finally evaluating the evidence and making a decision. Closing the record doesn’t become an issue, then, until the ALJ hearing.

Under current practice, ALJs and OHA staff continue developing the record, as needed, in order to set the case for hearing and decision. In addition, the claimant-appellant is free to submit supplemental evidence both before the hearing and at the hearing itself. This must be so, as the administrative hearing is a *de novo* review of the claim. Although claimants are expected to identify additional evidence that will be submitted at the time they request the hearing (see 20 C.F.R. §§ 404.933(a)(3), 416.1533(a)(3)), regulations also provide expressly that evidence can be submitted at the hearing as well. (See 20 C.F.R. §§ 404.950(a), 416.1550(a). (“Any party to a hearing has the right to appear before the administrative law judge, ei-

ther personally or by means of a designated representative, to present evidence and to state his or her position”).) Indeed, the Social Security Act guarantees as much: “. . . the Commissioner shall give [claimants] . . . reasonable notice and opportunity for a hearing with respect to [an adverse] decision, and, if a hearing is held, shall, *on the basis of evidence adduced at the hearing*, affirm, modify, or reverse the Commissioner’s findings of fact and such decision.” (42 U.S.C. § 405(b)(1) (*emphasis added*). See also 20 C.F.R. §§ 404.953(a), 416.1553(a). (ALJ directed specifically to decide the claim “based on evidence offered at the hearing or otherwise included in the record”).)

Moreover, the ALJ has an affirmative duty to assure that the record, including any live testimony offered by claimants and their witnesses, contains all of the information necessary to decide the case. See, e.g., *Washington v. Shalala*, 37 F.3d 1437, 1442 (10th Cir. 1994) (“Even when a claimant is represented by counsel, the administrative law judge ‘has a basic obligation in every Social Security case to ensure that an adequate record is developed during the disability hearing consistent with the issues raised’”) (quoting *Henrie v. U.S. Dept. of Health & Human Services*, 13 F.3d 359, 361 295 (10th Cir. 1993)). Thus, Social Security regulations provide that “[a]t the hearing, the administrative law judge looks fully into the issues, questions [the claimant] and the other witnesses, and accepts as evidence any documents that are material to the issues.” (20 C.F.R. §§ 404.944, 416.1544.)

Although less clearly stated and perhaps subject to some conditions, the record may still remain open even after the hearing. Sometimes the claimant will request additional time to obtain evidence and the ALJ will simply hold the record open for a set numbers of days after the conclusion of the hearing in order to give the claimant time to do so. The ALJ may also continue the hearing to a later date, pending receipt of additional evidence, or may reopen the hearing if additional evidence becomes available before the decision is issued. See 20 C.F.R. §§ 404.944, 416.1544 (“The administrative law judge may stop the hearing temporarily and continue it at a later date if he or she believes that there is material evidence missing at the hearing. The administrative law judge may also reopen the hearing at any time before he or she mails a notice of the decision in order to receive new and material evidence”). See also HALLEX § I-2-680 (C) (“If an ALJ decides to admit additional evidence into the record of a case, or to conduct a supplemental hearing, he or she must reopen the record”).

It is against this backdrop that one must examine the Commissioner’s complex proposed rules for submitting evidence and closing the record at the ALJ hearing. Among them are the following:

- Evidence must be submitted, with limited exceptions, at least 20 days before the hearing.
- Limited exceptions to the 20-days-before-hearing rule are left to the discretion of the ALJ.
- Ability to submit evidence after the hearing is left to the discretion of the ALJ.
- Evidence obtained after the hearing, even if it relates to an unforeseen change in medical condition that occurred after the hearing, must be submitted within 10 days of the decision, with no “good cause” exception.

Other new time limits imposed on claimants include a strict 10-day rule for objecting to the time and place of the hearing and the issues to be decided on appeal.

Not only is there no explanation for this radical departure from the current rules and practice that accept into the record any and all evidence offered at the hearing, the complex set of rules are a potential devastating trap for claimants. Even claimant lawyers will have a hard time keeping track of and managing these time limits; for unrepresented claimants, it will be all but impossible. Moreover, these strict limits would operate together with a rule that requires hearings to be set on 45 days advance notice, leaving only 25 days after notice of the hearing date to submit all evidence.

There is simply no good reason to limit the submission of evidence at the time of the hearing. Records are closed at some point in order to allow the decision-maker—in this case, the ALJ—to make a proper decision. The Commissioner’s proposal authorizes the ALJ to order pre-hearing statements; that approach, together with the assistance of a Reviewing Official/Counselor operating along the lines suggested above, should be sufficient to move the process along and assure that the ALJ will have a full and complete record when he or she must make a decision. The point is to provide the ALJ the record needed to make a prompt and accurate decision, not to cut the all-important record development function off at the pass. With respect to closing the record, the goal should be to get record development to the point where closing the record becomes a non-controversial matter.

Once steps are taken to allow the ALJ to decide cases based on a full and complete record, like those proposed above in relation to the new Reviewing Official/Counselor, then there should be no hardship in closing the record after the hearing (or at a later designated time set by the ALJ). Claimants' representatives can play their part along with the Reviewing Official/Counselor to produce everything that is needed for decision in a timely fashion. However, in some cases key information—key to both SSA and the claimant in their shared desire to produce a correct decision—cannot always be obtained in time. In such situations, a “good cause” exception for reopening the record before the ALJ should be available as a safety valve. In this context, the treatment of new evidence at the federal district court level can be instructive. Federal court review of SSA's final decision is based exclusively on the record developed at the administrative hearing or before the Appeals Council; new evidence in support of the claim cannot be introduced at the district court. However, if a claimant comes across “new and material evidence” after the administrative process is complete and can show “good cause” for failing to submit it earlier, the evidence can be presented to the court as a basis for remand. (42 U.S.C. § 405(g).)

In this regard, another proposal from the SSAB report referred to earlier—made in connection with the proposals for a new “Counselor” position—may be of some help:

SSA should revise its regulations to close the evidentiary record after the ALJ hearing, subject to the following qualifications:

- ALJs may extend the time to submit evidence and/or written argument for a reasonable period after the hearing and before deciding the claim.
- Claimants may request that the record before the ALJ be reopened for the submission of new and material evidence and a new decision, if the claimant demonstrates good cause for failing to present the evidence before the record closed and if the request is made within one year after the ALJ issued the decision on the claim or before a decision is reached on appeal by the Appeals Council, whichever is later.

Similar ideas were presented by ACUS in a 1990 supplementary recommendation, which addressed the need to have the evidentiary record be as complete as possible and as early in the process as possible. ACUS proposed that the record before the ALJ should be closed at a set time after the hearing, and set forth a specific recommended procedure as follows (ACUS Recommendation 90–4, *Social Security Disability Program Appeals Process: Supplementary Recommendation*, 55 Fed. Reg. 34,213 (Aug. 22, 1990), at ¶¶ 4–5):

4. *Closing of the Administrative Record:* The administrative hearing record should be closed at a set time after the evidentiary hearing. Prior to this, the ALJ should set forth for the claimant what information the claimant needs to produce to complete the record, issue any necessary subpoenas, and provide the claimant adequate time to acquire the information. Requests for extension should be granted for good cause, including difficulty in obtaining material evidence from third parties. The ALJ should retain the discretion to accept and consider pertinent information received after closure of the record and before the decision is issued.

5. *Introduction of New Evidence after the ALJ Decision:*

- a. Upon petition filed by a claimant within one year of the ALJ decision or while appeal is pending at the Appeals Council, the ALJ (preferably the one who originally heard the case if he or she is promptly available) should reopen the record and reconsider the decision on a showing of new and material evidence that relates to the period covered by the previous decision. An ALJ's denial of such a petition should be appealable to the Appeals Council.
- b. Appeals Council review of an ALJ's initial decision should be limited to the evidence of record compiled before the ALJ. Where the claimant seeks review of an ALJ's refusal to reopen the record for the submission of new and material evidence, the Appeals Council should remand the case of the ALJ (preferably the one who originally heard the case if he or she is promptly available), if it finds that the ALJ improperly declined to reopen the record. The Appeals Council should not review the merits itself or issue a decision considering the new evidence, unless remand would result in substantial injustice or unreasonable delay.

I suggest that the Commissioner's proposed rules on submitting new evidence and closing the record at the ALJ hearing be scrapped altogether and replaced with a simple statement that the record can be closed by the ALJ at some time after the hearing, subject to the type of exceptions set out in the SSAB and ACUS proposals

discussed above. Of course, both of those proposals were written to take into account Appeals Council review; any application of them to the Commissioner's new disability determination process would have to be modified if the Appeals Council is eliminated.

Chairman HERGER. Thank you, and I want to thank each of you for your testimonies and now we will turn to questions. The gentleman from Michigan, Mr. Levin, to inquire.

Mr. LEVIN. Thank you very much. Well, this has been an interesting hearing, and I think an important one, and I am really very glad we are doing this, because we all applaud the need to expedite procedures and I think that meant not only a new electronic system, but also some new regulations. I do think, though, the testimony brings out some real issues that not only does everyone outside of the Congress have to be involved with, but I think we do as well. I am not quite sure how we contemplate doing that. For example, the replacement of the Appeals Council—and I am not an expert on this—and I doubt if very many of us have ever had a chance to practice these cases if we are lawyers—as I understand it, what would happen would be the elimination of that step in a meaningful way and instead there would be a review by a new mechanism; right? We are eliminating another step; is that correct?

Mr. SUTTON. We are clearly eliminating a step. The only review, Mr. Levin, as I understand the proposal, is one that is based on sampling—a certain percentage of cases, favorable and unfavorable. Claimants would have no right to request a review, so there would not be review of cases at the request of claimants who are aggrieved.

Mr. LEVIN. Essentially, we would be changing the system so that after the ALJ decision, the next real appeal process would be a Federal court?

Judge MCKIBBEN. That is correct, Mr. Levin. That is one of our major concerns. The DRB would have the right to appeal both those claims that have been allowed and disallowed. There would be an internal review and only if they decided to review the case would they reveal, through the decision by the ALJ, that they were reviewing the case. It is hard to tell how many cases they would review or what the criteria they would use in making that determination, and our concern, of course, is the substantial number of cases that would come into Federal court if there wasn't an internal administrative review process.

Mr. LEVIN. No, but also I mean the expense for a claimant is dramatically higher, is it not? I am glad you are concerned about the flood of cases, but we also should at least be concerned about going to Federal court. We are talking about a considerable expense, and I am not sure how many of these cases involve how much money, but hiring legal counsel to go to Federal court is generally an expensive proposition unless it is done pro bono. Am I wrong?

Judge MCKIBBEN. There is no question that it is an expensive process and a number of litigants come in representing themselves. It is a difficult maze for them to negotiate. It is very difficult to go into Federal court.

Mr. LEVIN. Then so that would put more weight on the ALJ decisionmaking process, and I would think would raise more questions about the 20-day limit; no? How much abuse has there been? After all, the claimant is anxious for, isn't he or she, a speedy adjudication. By definition; right? I assume the decisions are retroactive, but, still, the person is without the monetary help. Is there, in your experience, and my time is running out, is there much abuse of the present system? Anybody know? Some of you have practiced this, so tell us.

Mr. MCDONALD. Well, speaking from the standpoint of the only hearing office that I can speak to, I think we do have some abuse, but, for the most part, we do not. We have pending in our office right now 9,500 cases. We have nine judges. Realistically, we are looking at a couple of years from the time of the filing of the hearing request until the time of the hearing. During that time, the medical evidence does come in, although it general doesn't come in until just before the hearing, so from the standpoint of the hearing offices, the really critical time is around the time of the scheduling of the hearing, because understandably representatives for the claimants don't want to get medical records, submit them, and then have to go back to the same medical sources to submit those records. It does tend to be that we get the medical records after a long delay, while people wait for their turn in the queue to have their hearings. I don't think that we have a real abuse of the submission of medical evidence for the most part.

Mr. LEVIN. I will finish. Why the proposed change if there isn't abuse of any size?

Mr. SUTTON. I think one of the—and I am not involved in the decision with regard to the 20-day limit, but it is true that, from an ALJ standpoint, to have records submitted at the very end, just prior to the hearing or brought to the hearing, lessens our ability to be educated about the medical record prior to the hearing and makes the hearing less effective. There is a need for having medical evidence submitted to the hearing office at some point prior to the hearing itself.

If I could add to the Judge's perspective, as someone who has represented thousands of these claimants over 20 years, in a perfect world we would have all the evidence more than 20 days before the hearing. We would love to have it. We are doing everything we can to get it. The Judge may have to and his staff may have to field some of these calls, but I and my staff have to field the calls from the claimants that you hear from in your offices. They are saying, why does it take so dadgone long, Mr. McCrery? They are calling us because we are their lawyer. Why is it taking so long? Why are we not getting there? There have been delays and backlogs in getting to hearing dates.

There are also delays with providers not coming across with records, and when we order them. We are sending checks out. We are sending advance payment, and it doesn't expedite the process. Some providers respond fairly quickly, but others, particularly the Veterans Administration, take forever as one example. What we are facing then here in these rules is something that will say—not to the representative you didn't do our job, and you didn't get the records quickly, so you are going to be penalized. It is saying to the

claimant, I won't consider these records unless I find there is good cause. If you demonstrate to me or your lawyer does that you have done everything possible, then maybe I will find good cause. A lot of ALJs will. Some simply won't. There will be these decisions that will simply go off on records that are not complete and artificially incomplete—where records actually were obtained and were submitted, but were submitted not long enough before the hearing, and then we will have a close record that is incomplete, where someone is meeting the disability definition, but the proof won't be in the file because someone will say, no, it didn't come in in time. That seems to us to be an outcome in a non-adversarial system that is trying to get at the truth of whether the person meets the statutory definition of disability a very bad outcome. Yes, the record does need to close at some point. Twenty days before the hearing, which is what these rules do, does not seem to us to be practical or workable.

Mr. BLOCH. If I may, this is why the idea that I presented with the use of someone in between the State agency decision and the ALJ participating actively and taking responsibility on behalf of the agency to see to it that the record is fully developed, we should get to the point where closing the record is not an issue because the evidence is provided and made available at the time of the decision. Of course, one other thing to point out is that it is true that in an ideal world, you get all the evidence prepared and able to present to the ALJ, but there is the hearing itself and at the hearing itself where there is testimony and additional evidence is brought, so I really don't see a reason why prior to that time there should be an absolute cut off and keeping out of the record information that could help make the decision better.

Ms. FORD. We, in fact, think that may violate the statute, the requirement that the Commissioner shall, on the basis of evidence adduced at the hearing, make a decision. Closing the record before the hearing and refusing to allow any of that evidence to come in, we think may, in fact, be a violation of the statutory requirement.

Chairman HERGER. Time has expired. The Chairman, Mr. McCrery, to inquire.

Chairman MCCRERY. Thank you, Mr. Chairman. Dr. Bloch, explain what this counselor that you suggest would do exactly. Would every case before an ALJ have an counselor assigned to it, and I suppose the counselor might have a number of cases assigned to him or her? That is what you are suggesting? That every case would have a counselor assigned to it?

Mr. BLOCH. Yes. Well, the proposal included in our original report to the Social Security Advisory Board that called for this position did have the position at the Office of Hearings and Appeals (OHA). Yes, at the OHA. The idea was to have that person serve as a bridge between the DDS, where, unfortunately, there is a long history of making decisions based on records that are not full and not complete, and using that opportunity to have the agency expend its efforts to come up with the additional evidence that an expert, someone trained in the information necessary to make the decision would do. This report, by the way, was written in part to address the question of having an adversarial process at the hearing, and this was thought to be a better way to approach the whole

problem, since the root of the problem was seen to be this concern that there was an inadequate record at the different levels of appeal.

Chairman MCCRERY. Okay. Well, according to the information I have seen, from the time that the ALJ decision is made, if that is appealed to the Appeals Council, there is another 251 days on average before the Appeals Council rules. Surely, there is a better way. The total, when you add up all those days from start to finish is over a thousand days. This is the average. Surely, there is a better way. Number one, I want to thank all of you for your constructive criticism of the Commissioner's proposal. I think you have made some suggestions that she can consider to refine her proposal and make it better at striking that balance between our desire to have a more speedy determination and making sure that the rights of the claimant are protected.

I appreciate the specificity with which you have made comments on the proposal. As this goes forward, I would urge each of you to be constructive in terms of arriving at a final proposal that will, in fact, cut down on that thousand days that it takes this poor person to get a conclusion. As I said before, that is the biggest complaint I hear. A lot of people can take no for an answer, but it just tears their guts out to wait day after day, week after week, month after month, and year after year to get that no. I urge you to work with the Commissioner to get a final proposal done that can maybe get that amount of time reduced. Mr. Sutton, I saw you eager to say something.

Mr. SUTTON. Well, Mr. Chairman, I appreciate that, and we, again, have those same phone calls that I think you hear in your office. As the Commissioner pointed out, that processing time of the Appeals Council has decreased. Believe it or not, that is faster than it used to be.

Chairman MCCRERY. I know.

Mr. SUTTON. It could be a lot faster still, and we could come up with something to allow people to bypass that if it becomes too much of a bottleneck. The problem that we have with this proposal is that in its absence, we have for the claimant nothing. The claimant is basically left with the door to the courthouse, a \$250 filing fee, finding an attorney who does this kind of work on a contingent basis or a pro bono basis, and hoping for the best, where the record is it may simply not be the record that was necessary to make a complete decision.

Chairman MCCRERY. I understand that. Unfortunately, we can't arrest the doctor for not providing the record.

Mr. SUTTON. That is correct.

Chairman MCCRERY. We are not going to have a perfect solution to this. Trust me. Let's deal with reality and get the best proposal that we can possibly get, and you all have a ton of expertise in this area, so I urge you to work with the Commissioner, once again, to get us a proposal and not just stick with what we got, because what we got I believe is not working well. Just one other comment on allowing evidence after the hearing to the ALJ, I would work very hard to minimize that, because there is no way that an ALJ, without the benefit of a face-to-face hearing can analyze properly the source of that document, the source of that mate-

rial, the source of that evidence, the validity of the evidence. That just is not fair to the ALJ. He has got to have some person in front of him that he can cross examine and he can probe and make sure that that is the best evidence available.

Mr. SUTTON. Mr. McCrery, if I could address it, I believe that is absolutely correct from the perspective of the ALJ. Remember, however, I am an attorney. I have a law firm; resources behind me. I cannot in 100 percent of the cases where I represent the claimant at the hearing get all the records, even by the date of the hearing.

Chairman MCCRERY. As I have said, we are not going to find a perfect solution.

Mr. SUTTON. We do the best we can, and the ALJs are generally very good about what has to be done to make sure the record is complete. That is me and that is my law firm. Now, what do we do about the 53 percent of SSI claimants who are unrepresented? The almost a quarter of Title II claimants who are unrepresented, who have to fend for themselves, who now are confronting regulations that are going say 20 days before the hearing, or I don't have to consider it?

Chairman MCCRERY. No, I—

Mr. SUTTON. That is the problem.

Chairman MCCRERY. —there may be some problems with the time lines, and I think you make some good points along those lines. As I say, there has got to be a better way than what we are doing, so let's get one. Thank you all very much.

Chairman HERGER. Thank you. The gentleman from California, Mr. Becerra to inquire.

Mr. BECERRA. Thank you, Mr. Chairman, and thank you to all the panelists. I appreciate our testimony. Let me ask a quick question and hopefully get a couple of quick answers if you would like—but quick answers to this. It sounds like we are hearing more or less the same thing—the concerns that are being raised. Everyone applauds the work that the Commissioner and the SSA are doing to try to move this forward to get us a better process, a faster process. For the most part, I think we all agree that there are some concerns out there that were not completely addressed. A quick question to you: If you raise these concerns today, you must have raised them before to the Commissioner, to the SSA, and if you raised them before to the SSA and the Commissioner, what was the response?

Judge MCKIBBEN. Well, I can say from the Judiciary's standpoint that we raised these issues about the Appeals Council and the elimination of the Appeals Council and the right of review a couple of years ago, and she has been very responsive to that, and has moved in the direction of trying to develop some type of a pilot project to see what impact it has both on the claimant and also on the courts. It seems to me that, with the DRB, if it is going to do as the Commissioner suggests it should do, then if you still embody the right of appeal and review by the Review Board, even though it may be in some aspects a summary review with the data that they have, that would still ensure that the claimant has the right of review. That seems to make some sense to me and probably would meet within the confines of the judicial policy on this.

Mr. BECERRA. Judge, to some degree, do you think that embodied in these proposed regs are the concerns that you have all expressed?

Judge MCKIBBEN. She certainly has gone a long way toward addressing some of those concerns.

Mr. BECERRA. Okay. Anyone else?

Mr. SUTTON. Just one thing, Mr. Becerra, we appreciate the Commissioner has consulted with a lot of the stakeholders, including our organization, and really has gone out of her way to do that. There is one exception here that I must point out to the Committee, which is this proposal to bar in all circumstances a reopening of prior determinations because of new material evidence. To my knowledge, that was not in the Commissioner's original testimony to this Committee 2 years ago. It was never mentioned in any of the meetings that we had or were privy to. I never heard about it before, and was quite dumfounded to read that in this proposal.

We see cases—these are not—this is not the majority of cases—they are just certain cases, and they stick out like sore thumbs. We had a client recently where she had been denied benefits—excuse me—he had been denied benefits at a time when his insurance had expired. We tried to help this gentleman. We got him an evaluation, and the doctor who saw him said, quite unsolicited, “I believe this individual is very slow. He should really be evaluated.” An ALJ ordered a psychological evaluation, and it was discovered, in fact—you put it together. This man had been mentally retarded his entire life. Now he had major physical problems in addition, so he couldn't work anymore. That judge was able to use that new evidence to reopen a denial and give this man the insurance benefits that he had worked for and earned in his life.

Mr. BECERRA. I agree with you. That, to me, as I mentioned to the Commissioner, was the one area that concerned me the most. Let me ask, Ms. Ford, a couple of questions. How much latitude should we grant to claimants before finally the door closes for any lack of diligence or action on the part of the claimant?

Ms. FORD. Well, I think that what exists under the current regulations, although I know that folks think this is part of what eats up the time, I think that the current structure allows for what is necessary to go back and fix something on the part of the claimant. If the claimant has not been able to get the evidence and the ALJ has the ability to bring it into the case. When the claimant gets to the Appeals Council, the rules are stricter in terms of what can be allowed in—and then at Federal court.

Mr. BECERRA. Tell me—is there something—are you saying keep the current rules in place in terms of the claimant's obligations to respond? To change them in certain ways? Rather than have you have to answer here, because I am running out of time, do me a favor. Send us anything that says what are the parameters under which claimants should operate, because part of the delays are due, in many cases to the claimants. In many cases, as Mr. Sutton just pointed out, it is not because they are not intending to respond. It is they are not capable of fully responding.

Ms. FORD. Right.

[The information was not received at time of printing.]

Mr. BECERRA. Mr. Sutton, now let me ask you a question. How do we get those different stakeholders to respond—the doctors, the others? How can we get them to where we need them to be and respond quicker? Actually, do me a favor. I am running out of time. Send me something in writing, because I won't have—if I ask you that, I can't ask one final question I want to ask Ms. Ford.

Mr. SUTTON. Very well.

[The information follows:]

Mr. BECERRA. Give us something that gives us a sense—how can we compel, or if not compel, persuade some of the other stakeholders to get us the information we need to adjudicate these cases. I know my time has expired, so, Mr. Chairman, real quickly to Ms. Ford. What happens with kids? If you have got a child who is the claimant and the parents aren't that sophisticated in moving through the process, what could happen to a child if we have these rigid standards that we are working with under these proposed regs?

Ms. FORD. I think that the regulations would apply equally to children, and so if their families are not able to maneuver through the system, the children, who may very well be disabled, according to the rules, could be found not disabled because they weren't able to get the evidence in on time; and so would be without the kind of support that would be needed to help them overcome some of their disabilities. Especially for children, early intervention is critical. The earlier you can get support to a child, the better in terms of their lifelong capacity to deal with the disability.

Judge MCKIBBEN. Mr. Becerra, to follow up on the last question that you had of me, I think the critical thing is that there has to be a review of right in the administrative arena before a claimant ends up having to go to Federal court.

Mr. BECERRA. I agree with you.

Judge MCKIBBEN. I think that is absolutely critical.

Mr. BECERRA. I agree with you. Mr. Chairman, thank you very much.

Chairman HERGER. I thank the gentleman from California, and I want to thank each of our witnesses here today. Obviously, this is an area that is crying for reform. To reduce the amount of time it takes to come up with a disability decision and to ensure that we do make the proper and correct decision as soon as we can certainly is something that I know we are all dedicated to do. With that, I want to thank each of you for testimony and for your suggestions. They have been noted in the record. With that, I adjourn this hearing.

[Whereupon, at 6:35 p.m., the hearing was adjourned.]

[Questions submitted from Mr. Levin to Commissioner Barnhart, Ms. Ford, and Mr. Sutton, and their responses follow:]

Questions from Mr. Levin to Commissioner Jo Anne B. Barnhart

Question: The proposed rule institutes many new requirements and time lines for the appeals process, making it much more formal and complex. How would disability claimants be expected to negotiate this? Does this proposal envision that all claimants appealing an initial denial will be forced to hire professional representation, and do so prior to filing an appeal, in order to comply fully with these deadlines?

Answer: I intend to maintain the agency's longstanding commitment to a non-adversarial appeals process. I want to assure you that our objective is to expedite disability decisionmaking, improve accuracy, consistency, and fairness of decisions, and to make the process better and more understandable to claimants, not to create hurdles for them. The Social Security Administration (SSA) is, and always will be, mindful of the special needs of unrepresented claimants. While a lawyer or other representative often provides helpful service to a claimant, we do not believe that all claimants should need or feel compelled to obtain representation. We believe that most disability claimants will be able to comply with the proposed procedures and timelines, and where they cannot, we believe our proposed rules should provide the Agency with the ability to address their needs. Under our proposed rules, the claimant would still have the opportunity to explain why we should consider evidence that could not be provided timely. Providing good service to claimants requires timely processing as well as attention to the needs of individuals. I intend to carefully consider the comments we receive on our proposed regulations with this objective in mind.

Question: Creating a deadline for claimants to submit evidence prior to the hearing may not necessarily result in a more complete development of the record, given the well-established difficulty in obtaining medical evidence and the fact that a disabled claimant is unlikely to know precisely the kinds of evidence needed to establish his or her claim. What other elements of your proposed rule will lead to better, earlier and more complete development of the evidentiary record—especially at the initial and Reviewing Official levels? Are there particular steps aimed at ensuring that relevant medical and other evidence are both identified and actually obtained by SSA or the state agencies?

Answer: I very much appreciate your question—particularly in its approach to the overall submission of evidence throughout the process. We are proposing to establish timelines for the submission of evidence at the hearing level in an effort to ensure that the administrative law judge (ALJ) has the most complete record to review just before the hearing. But, that is just one aspect of the proposed rules pertaining to development and submission of evidence. Our focus is to create a more complete and well documented record much earlier in the process.

The SSA is proposing a number of changes that will help us achieve these goals:

- At the initial claim level, we are using our new electronic disability process (eDIB) to improve the record that the field office sends to the disability determination services (DDS). We will continue to improve this process.
- The Notice of Proposed Rulemaking proposes that the DDSs better document each case and provide more complete rationales for their determinations. The proposed Federal Expert Unit will help DDSs, as well as all other levels of adjudication, to obtain the medical documentation they need—particularly in difficult to determine areas of impairments—improving the medical record and the quality of medical and vocational expertise we devote to a claimant's case.
- At the Reviewing Official level, our proposal to fill this position with Federal employees who are attorneys should ensure nationwide uniformity in the application of policy. It also should result in enhanced rationales and clear decisions that our claimants will better understand. The Reviewing Official decision will provide a claimant with the information needed to make an informed judgment about pursuing an appeal to the ALJ level, and a better record for the ALJ should the claimant request a hearing.
- Feedback loops would be established at each level of adjudication, ensuring continuous improvement in better documenting each case. A new and more balanced quality review system that will review both allowances and denials should also assist in continuous improvement and the development of more complete records.

Question: Please enumerate the reasons why a hearing might be postponed or rescheduled. Has the Social Security Administration or individual hearing offices conducted any analysis of the reasons for postponements, and/or adopted strategies or procedures to try to reduce the frequency of postponements?

Answer: Each Hearing Office records information about the reasons for hearing postponements and cancellations. In Fiscal Year (FY) 2005, our analysis indicated the reasons for hearings postponements and cancellations were:

- the claimant or representative did not appear for the hearing;

- the claimant requested representation after the case was scheduled;
- a dismissal issued by the ALJ after the case was scheduled;
- the claimant was unavailable;
- an on-the-record decision was issued by the ALJ after the case was scheduled;
- and
- other reasons, including failure to provide evidence.

We have developed “best practices” to help reduce postponements or cancellations and have shared them with all hearing offices. These “best practices” include:

- Providing representatives with case listings, on a monthly basis, as cases move to within 60 to 90 days of being scheduled to concentrate their efforts on obtaining and submitting medical documents in time for the scheduled hearing(s);
- Telephoning non-represented claimants before the hearing and reminding them of the hearing date
- Identifying representatives who are willing to schedule cases quickly to fill in postponements or cancellations;
- Scheduling hearings at least 3 months in advance.

Question: If a representative engaged in a pattern of withholding evidence, postponing hearings or otherwise delaying decisionmaking unnecessarily, does SSA have tools or procedures in place to sanction such conduct? How many times have these been invoked in the last 3 to 5 years?

Answer: Yes. The SSA does have representative sanction procedures in place. When we have evidence that a representative fails to meet our qualification requirements or has violated the rules governing dealings with us, we may begin proceedings to suspend or disqualify that individual from acting in a representational capacity before us. Specifically, representatives have an affirmative duty to assist the claimant in complying, as soon as practicable, with our request for information or evidence. For further information, see sections 206(a), 1102(a) and 1631(d)(2) of the Social Security Act and our regulations at 20 CFR 404.1740, 404.1745, 404.1750, 404.1765, 416.1540, 416.1545, 416.1550, and 416.1565.

We do not keep data specific to individual reasons for sanctions; however, below is information on the number of times representatives have been sanctioned in the last 5 years.

Representative Sanction Case Information for FY 2001 through FY 2006
(October 2005)

	Number of Formal Complaints SSA Filed Against Representatives	Number of Cases in which Representatives Accepted Suspensions or Disqualifications Before SSA Filed Formal Complaints	Number of Cases in which Representatives Accepted Suspensions or Disqualifications After SSA Filed Formal Complaints	Number of Cases in which SSA Issued Final Decisions to Suspend or Disqualify Representatives
FY 2001	25	0	2	7
FY 2002	15	1	1	12
FY 2003	5	4	5	4
FY 2004	5	0	0	4
FY 2005	6	1	1	4
FY 2006	2	0	0	1
TOTAL	58	6	9	32

Note: After FY 2001, we started increasing our use of an informal process, which reduced the number of formal complaints filed against representatives.

Question: SSA previously tested eliminating a claimant’s right to appeal an Administrative Law Judge’s decision to the Appeals Council, as part of its “prototypes” demonstration projects. Does SSA have any data from that demonstration that suggest the Appeals Council—or similar body—can be eliminated without a significant increase in federal court filings?

Answer: In 1997, we began to study this issue during our previous prototype redesign effort, but we curtailed the review before it was completed once it became clear

that SSA was not going forward with this element of the prototype model. Therefore, there are no data available.

Question: How does the so-called “windfall offset” apply in Special Disability Workload (SDW) cases, and what does this mean in dollars and cents to the recipient? How many SDW cases are currently outstanding?

Answer: The SSA applies Title II/Title XVI windfall offset when an individual is eligible for Supplemental Security Income (SSI) payments and becomes retroactively entitled to Title II benefits for some or all of the months of SSI eligibility. Since SDW cases involve SSI recipients who become concurrently eligible for retroactive Title II benefits, windfall offset applies. The windfall offset provision requires SSA to reduce the retroactive SDW payments by the difference between the amount of SSI payments that were paid and the amount of SSI payments that would have been paid had the Title II benefits been paid timely.

As of the end of September 2005, SSA had processed 127,287 cases, leaving about 172,713 cases to be completed. SSA expects to complete the processing of all remaining cases by the end of FY 2010.

Questions from Mr. Levin to Ms. Marty Ford

Question: In your judgment, what would be fair parameters under which claimants could be expected to operate in terms of submitting evidence, etc. at the various steps of the appeals process?

Answer: The members of the CCD Social Security Task Force strongly support the submission of evidence as early as possible. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record is not beneficial to claimants including: (1) the need to keep the process informal; (2) changes in the medical condition which forms the basis of the claim; (3) the fact that the ability to submit evidence is not always in the claimant's or representative's control; and (4) claimants often secure representation at different times, often not understanding why representation is so important. For these reasons, the record should not be closed prior to the hearing decision. Even after that decision, it should be possible for claimants to file new and material evidence with the approval of the ALJ or the Appeals Council/Decision Review Board. As is discussed further below, the statute already provides that the federal district courts can remand a case “at any time” for consideration of evidence that is new and material and for which there is good cause that it was not previously provided. At a minimum, this standard should apply after the ALJ decision and before the Appeals Council/Decision Review Board (which also needs to have the ability to review claimant-initiated appeals, something not contemplated in the proposed regulations but which is an important current protection that needs to be maintained).

- The current system provides a process to submit new evidence at the ALJ hearing and, if certain conditions are met, at later appeals levels. So that claimants are not penalized for events beyond their control, the opportunity to submit evidence should not be eliminated in the name of streamlining the system. We believe that the current rules for submission of evidence should be retained as follows:
- Under current law, an ALJ hears a disability claim *de novo*. New evidence can be submitted up to and during the hearing and will be considered by the ALJ in reaching a decision. The statute is clear that the ALJ's decision is to be based upon evidence “adduced at the hearing.” Evidence that becomes available after the hearing but before the ALJ decision is issued receive the same treatment.
- The claimant should retain the right to submit new and material evidence after the ALJ decision. Current law sets limits for submission of new evidence after the ALJ decision is issued and these rules should be retained. At the Appeals Council level, new evidence will be considered, but *only* if it relates to the period before the ALJ decision and is “new and material.”¹ This should be retained at the Appeals Council or Decision Review Board level. SSA should recognize a “good cause” exception for this post-ALJ decision submission of new and material evidence.
- At the Federal district court level, the record is closed and the court *will not consider* new evidence. However, under the Social Security Act,² there are two types of remands:

¹ 20 C.F.R. §§ 404.970(b) and 416.1470(b).

² 42 U.S.C. § 405(g).

1. Under “sentence 4” of 42 U.S.C. § 405(g), the court has authority to “affirm, modify, or reverse” the Commissioner’s decision, with or without remanding the case; and
2. Under “sentence 6,” the court can remand (a) for further action by the Commissioner where “good cause” is shown, but only before the agency files an Answer to the claimant’s Complaint; or (b) at any time, for additional evidence to be taken by the Commissioner (not by the court), but only if the new evidence is (i) “new” and (ii) “material” and (iii) there is “good cause” for the failure to submit it in the prior administrative proceedings.

A construct could be adapted for “good cause” determinations for submitting new evidence. It is important that the regulations do *not* include an exhaustive list of reasons since each case turns on the facts presented. The “good cause” exception for district court “sentence six” remands for new and material evidence is well developed. A review of published court decisions shows a wide variety of reasons why evidence was not submitted prior to the court level, including:

- Medical evidence was not available at the time of the hearing.
- The claimant was unrepresented at the hearing and the ALJ did not obtain the evidence.
- Medical evidence was requested but the medical provider delayed or refused to submit evidence earlier.
- The claimant underwent new treatment, hospitalization, or evaluation.
- The impairment was finally and definitively diagnosed.
- The claimant’s medical condition deteriorated.
- Evidence was thought to be lost and then was found.
- The claimant’s limited mental capacity prevented him from being able to determine which evidence was relevant to his claim.
- The existence of the evidence was discovered after the proceedings.
- The claimant was unrepresented at the hearing and lacked the funds to obtain the evidence.

Since there are many permutations, depending on the circumstances in each case, there should be some discretion to consider new and material evidence, taking into account whether the circumstances involved show that good cause exists. The key is to ensure that the process is fair, informal, not overly legalistic, and that SSA has the information it needs to make full and fair decisions in each individual’s case. Anything less than that undermines the important guarantees of the Social Security program to be there when a worker or the worker’s dependents need it due to disability, death, or retirement. We understand that is not as high speed, streamlined, and efficient as a process that moves forward without all of the needed evidence, but this is the balance needed to ensure that the program is fair. Meanwhile, we absolutely support the concept that claimants and their representatives should provide the evidence they have as early as it is available, because that is in the claimant’s interest, as well as SSA’s.

Thank you for this opportunity to provide comment on these issues. I would be happy to respond to any further questions.

Questions from Mr. Levin to Mr. Thomas Sutton

Question: Why would a claimant or a professional representative seek to postpone a hearing? What factors are weighed in deciding whether to seek a postponement?

Answer: The primary reason that an unrepresented claimant would seek to postpone a hearing would be to obtain representation. Under SSA’s own policies, before a waiver of the right to counsel is considered valid, the ALJ must both send a letter to the claimant in advance explaining that right and confirm on the record at the hearing that the ALJ again told the claimant about the right to counsel and determined that the claimant was competent to understand. HALLEX I-2-6-52A.¹ If the claimant wishes to obtain representation, the ALJ should postpone the hearing. *Id.*

We encourage our members to seek postponements as infrequently as possible because of the length of time claimants must wait for a hearing date and because of the potential disruption to the overall hearings process. However, there are cir-

¹“HALLEX” is the acronym for SSA’s “Hearing, Appeals, and Litigation Law Manual.” The HALLEX conveys guiding principles, procedural guidance and information to the Office of Hearings and Appeals (OHA) staff. It also defines procedures for carrying out policy and provides guidance for processing and adjudicating claims at the Hearing, Appeals Council and Civil Actions levels. HALLEX I-1-0-1. It is available online at: http://www.ssa.gov/OP_Home/hallex/hallex.html.

cumstances when a postponement is necessary to adequately represent the claimant. One of the main reasons that a representative may seek a postponement of a scheduled hearing is when the claimant seeks and obtains representation shortly before the hearing or after receiving the hearing notice, frequently fewer than 20 days before the hearing date.² Based on the experience of our members, this is not an uncommon occurrence since the ALJ hearing is the claimant's first in-person contact with an adjudicator (this would not change under the NPRM). It should be noted that the current regulations state that a good reason for requesting a postponement is when the representative is appointed within 30 days of the scheduled hearing date and needs additional time to prepare.³

Under this circumstance, whether a representative and claimant decide to proceed with the scheduled hearing or request a postponement will normally depend on the quality of the records already in the hearing record file. After representation is obtained, the representative will need time to review the file in order to formulate legal arguments and, most importantly, develop additional evidence. If further evidence is needed to fully develop the claim, which is typically the case, then additional time will be required to request and obtain the records and other information.

The other most frequent reason for requesting a hearing postponement is that the claimant is ill or hospitalized. SSA's regulations require the ALJ to reschedule the hearing in this circumstance.⁴

Other reasons for requesting a postponement include:

- Serious illness or death of a family member.
- Lack of transportation to the hearing site. This is a problem not only in urban areas where there is mass transportation but the claimant lacks funds to pay the fare, but also is a problem for claimants who reside in rural areas and small towns and must travel some distance to a hearing site.
- The claimant is homeless or is being evicted.
- The representative has a scheduling conflict.
- The claimant cannot be located.

SSA's regulations, 20 C.F.R. §§ 404.936 and 416.1436, provide a nonexhaustive list of reasons, including many listed above, for requesting that the hearing be rescheduled.

Factors considered by representatives in deciding whether to seek a postponement include:

- The length of time the claimant has waited for a hearing.
- The claimant's medical condition.
- The claimant's financial situation.
- Whether further development is needed.
- The impact on the system.
- What the client/claimant wishes to do.

Decisions will not necessarily depend on a single factor but will involve a discussion with the claimant. Ultimately, the decision rests with the client, after the benefits and risks have been explained.

Question: In your experience, what are some of the reasons for delay in obtaining evidence? What are some of the obstacles encountered in developing a complete evidentiary record? Please describe the procedures your office and other NOSSCR members utilize in obtaining needed evidence.

Answer: Our office procedures are designed to efficiently order, procure and submit medical and other evidence which will result in favorable decisions for our clients at the earliest possible time. We employ staff who work full-time doing nothing but sending out requests, following up by phone call and fax, and reviewing responses for completeness. Nevertheless, like all representatives, we face numerous obstacles and lengthy delays in a significant number of cases. Based on our review of cases in which claimants tried to proceed without representation, the problems with developing a complete evidentiary record are even worse for the pro se claimants.

Problems with developing complete evidentiary files are many and varied, and include the following:

²Under current regulations, only a 20-day notice is required. 20 C.F.R. §§ 404.938(a) and 416.1438(a).

³20 C.F.R. §§ 404.936(f)(2) and 416.1436(f)(2).

⁴20 C.F.R. §§ 404.936(e)(1) and 416.1436(e)(1).

- Physicians who are understaffed, have copying and/or fax machines which are reportedly broken, and/or clearly do not see fulfilling record requests from attorneys as a high priority;
- Physicians who do not want to provide any records until a past-due bill for medical services is paid by the claimant;
- Physicians who will provide only their handwritten and marginally legible treatment notes, but will not take the time to write a letter or complete a form regarding their patients' impairments and functional limitations, regardless of whether a fee is offered for their services;
- Hospitals which have either closed or changed ownership, which often results in records being transferred to other sites with no notice to former patients;
- Hospitals which, for good reason, will not release records of inpatient hospitalizations until the attending physician signs the chart, which may take weeks or even months after discharge;
- Hospitals which cannot locate Emergency Room treatment records unless they are given a specific date of treatment, which claimants often cannot remember;
- Hospitals which insist on receiving their own form releases, even when a general HIPAA-compliant form has already been executed by the claimant;
- Mental health outpatient treatment centers which erroneously claim that HIPAA prohibits them from releasing psychotherapy notes;
- Claimants who, because of mental impairments, are unable to recall all of their treatment sources (e.g., a claimant with a hearing scheduled in early November who, despite repeated questioning, cannot remember what hospital he was psychiatrically admitted to for a period of several weeks);
- Claimants who have used different names in the past, making location of their records difficult if not impossible.

In addition to this nonexhaustive list of problems, it should be noted that virtually all providers expect pre-payment for copies of records. While some states have statutes which limit the charges that can be imposed by providers, many do not. Moreover, while private attorneys have the resources to advance costs for their clients, many legal services organizations do not, and unrepresented claimants may withdraw their requests for records in the face of what are, for them, significant bills which they cannot afford to pay. Finally, although ALJs have the nominal power to issue subpoenas at 20 C.F.R. §§ 404.1450 and 416.950, they do not have the power to enforce subpoenas with which providers fail to voluntarily comply, and the United States Attorneys' offices which have such power do not have the resources to devote to such activities.

Question: What can be done to improve the responsiveness and timeliness of those requested to provide medical and other evidence? How could we compel or persuade them to respond?

Answer: As discussed in the answer to question 2, there are many reasons for delays in obtaining medical evidence. Ways to improve the responsiveness and timeliness include:

- Provide adequate reimbursement rates to providers.
- Contact providers on a repeated basis. Medical providers, whether hospitals, clinics, physicians, or other sources, are extremely busy. We find that usually after three or four requests or calls, the provider will respond, but that requires allocation of personnel time by representatives and entails delay in submission of evidence.
- HIPAA has a 30-day response time requirement. However, many medical facilities are simply unable to comply. There is no penalty if they fail to comply.

Formal judicial proceedings have strict discovery rules and sanctions if they are violated. Similarly strict rules would be inappropriate in the disability claims process which is informal and nonadversarial. One tool that is available to a representative is requesting that an ALJ issue a subpoena for production of records. 20 C.F.R. §§ 404.950(d) and 416.1450(d). The request must be made at least 5 days before the hearing (the proposed rule would increase the time to 20 days before the hearing). While there is no effective way to enforce the subpoenas, our members report that providers frequently will respond to the records request once the subpoena is received. Even with a subpoena, additional follow-up contact with the provider will be needed. However, we do not ask for subpoenas in every case as we recognize the additional burden such a request places on ALJs and their offices.

Question: Why might a claimant or professional representative present evidence at the hearing itself, rather than submitting it in advance?

Answer: At the hearing on September 27, 2005, ALJ Dana McDonald was asked whether there was much abuse of the system so far as late submission of evidence. He responded that there was no real abuse of the system. He noted that often evidence comes in shortly before the hearing and he recognized that representatives cannot request medical evidence on a frequent basis. We agree with ALJ McDonald.

The most frequent reason for presenting evidence at the hearing, rather than in advance, is that it is received shortly before the hearing. We find, and other members report, that OHAs have difficulty associating medical records with the claimant's file in a timely manner. If it is shortly before the hearing (e.g., 10 days), the representative will take the records to the hearing or hand-deliver them in advance. Even in the latter case, a duplicate set may be taken to the hearing.

Even where evidence has been sent well in advance of the hearing, representatives will take a duplicate copy to the hearing because, in their experience, the original records are misplaced at the hearings office and will not be in the file. Some ALJs routinely instruct representatives to bring another copy to the hearing since it is so likely that the mailed records will not have been placed in the file.

Also, claimants wait many months for a hearing and, as ALJ McDonald noted, medical providers cannot be asked repeatedly to update records. As a result, initial requests may occur when claimants first retain representation and then again closer to the hearing. However, the current regulations require only a 20-day notice. As a result, despite our intensive efforts to obtain updated records for the ALJ, it is not at all certain that they can be obtained prior to the hearing. If the records are obtained, it usually will be too close to the hearing date to send them by mail. We believe that a long notice period will significantly improve the earlier submission of evidence. In the NOSSCR comments to the proposed rule, we recommended a 90-day notice.

Another reason for submission of evidence at the hearing is that representatives frequently are prohibited by certain OHAs from reviewing the evidence file until the hearing is scheduled. And, until the file is reviewed, they cannot determine exactly what additional records development is needed. This problem has been exacerbated by the increase in the use of video conferencing (VTC) for hearings. This means that the ALJ will be located at a different location than the claimant. While the representative should have access to the file before it is transferred to the ALJ's OHA, this usually does not occur. As a result, representatives are in the unfortunate position of having to negotiate with distant OHAs for access to the exhibit files. The distant OHAs respond in various ways, including sending the file but only 2 weeks before the hearing or sending only a List of Exhibits but not the actual records.

Question: With respect to the 20-day rule for submission of evidence, why isn't the "good cause" exception sufficient protection for claimants? Could your objections to other deadlines in the proposed rule be overcome by adding "good cause" exceptions?

Answer: "Good cause" decisions are completely within the discretion of the adjudicator. If the ALJ finds no good cause and rejects the evidence, a claimant will have no recourse to have the evidence considered, other than to file an appeal to federal court or simply abandon the claim. Under the proposed rule, claimants will have less than 25 days after receiving the hearing notice (45-day hearing notice requirement less 20 days to submit evidence before the hearing) to submit all updated medical records. However, nothing requires medical providers to turn over records this quickly. Claimants will then be at the mercy of ALJs to find good cause. Some will do so. But others may rigidly enforce the new 20-day deadline and refuse to consider any medical evidence submitted within that time limit and even deny the claim based on an incomplete medical record.

If the ALJ's discretion is abused, the claimant will have no recourse within the agency, but instead will have to file suit in federal court where a district court judge will be asked to decide not whether the evidence proves disability, but whether the ALJ was wrong to refuse to consider the evidence. As a result, the 20-day time limit will result in decisions based on incomplete records which cannot be repaired and will lead to unnecessary litigation.

A good cause exception to the 20-day rule also may be more burdensome not only for claimants and representatives but also for ALJs. If all necessary evidence has not been received at least 20 days before the hearing, it may be necessary to ask the ALJ for a good cause determination and/or to issue a subpoena. Since it is extremely unlikely that *all* evidence will be obtained more than 20 days before the hearing, requesting a good cause determination and/or that subpoenas be issued may become a routine matter at hearings. The ALJ will need to address these

issues, leading to more litigation over these tangential, yet crucial, matters and ultimately leading to longer hearings.

These results are not only unfair to claimants but are also administratively inefficient and thus do not advance the Commissioner's goals.

Extending the use of good cause to other time limits in the proposed rule is not helpful to claimants for the reasons discussed above, primarily, that it is a discretionary decision for which the claimant has no recourse.¹ We believe that such unlimited discretion will not improve the system but will make it worse.

Question: What barriers and obstacles do claimants face in pursuing an appeal in Federal court?

Answer: We support the current system of judicial review. We believe that both individual claimants and the system as a whole benefit from the federal courts deciding Social Security cases. Over the years, the federal courts have played a critical role in protecting the rights of claimants. The system is well-served by regular, and not specialized, federal judges who hear a wide variety of federal cases and have a broad background against which to measure the reasonableness of SSA's practices. Under the current system, the courts are more geographically accessible to all individuals and give them an equal opportunity to be heard by judges of high caliber.

However, as noted by Judge McKibben in his testimony at the September 27th hearing, there is a large dropoff in appeals from the Appeals Council to federal court under the current process. Based on our experience, the two main factors are (1) the complexity of the process, which intimidates claimants (especially those who are unrepresented), and (2) the cost, which is prohibitive for many individuals. Overall, it is very difficult for a claimant to win a case in court without the assistance of legal counsel.

As noted by Judge McKibben, there are other factors contributing to the decision not to appeal to court. These include the fact that some attorneys do not take cases to federal court; some representatives are not attorneys; and many attorneys do not take cases to federal court if they did not represent the claimant at the hearing. Judge McKibben noted another important factor: the existence of the right to seek administrative review of unfavorable ALJ decisions.

Federal court appeals are more costly than appealing to the Appeals Council. The procedure to request review by the Appeals Council is relatively simple. SSA has a one-page form that can be completed and filed in any Social Security office, sent by mail, or faxed. In contrast, the procedure for filing an appeal to federal district court is much more complicated and, unless waived, there is a \$250 filing fee, which may be cost-prohibitive for a claimant. While the fee may be waived, it involves filing a motion to proceed *in forma pauperis* and then waiting for a decision granting the motion. Although court personnel are generally helpful, pro se claimants are nevertheless intimidated by this process.

Federal court appeals are more complex than appealing to the Appeals Council. In contrast to the filing of a simple one-page form to request review by the Appeals Council, filing an appeal and following through with the case in federal court is much more complex and governed by procedural rules since it is an adversarial process. A formal Complaint must be filed, which then must be served on the appropriate federal officials. A transcript of the administrative proceedings is prepared by the agency and is then served on the plaintiff/claimant. That is followed by a briefing schedule set by the court. The plaintiff/claimant must then wait for a decision by the court, which can be a long wait depending on the press of other cases before the court. And if there is no intermediate administrative appeals process, the delays may be even longer than those that currently exist. As noted by Judge McKibben in his testimony:

“[T]he acceleration of district court review of disability claim denials may result in more costs and further delays for claimants because it merely shifts the time for considering such claims from the administrative process to the courts.”

It is also important to note that many claimants have impairments or other limitations that affect their ability to navigate the system, e.g., they have mental impairments, are illiterate, are not fluent in English, or are homeless. Filing an appeal to an administrative body like the Appeals Council is much easier and far less intimidating than filing an appeal in federal court.

Another obstacle for claimants is that the record is closed once the case is at the federal court level and new evidence cannot be considered by the court. Unlike the *de novo* standard used by ALJs in making findings of fact, the courts are limited,

¹Not all actions by SSA give the individual the right to administrative and judicial review. See 20 C.F.R. §§ 404.902 and 416.1402.

by statute, to determining whether findings made in the administrative process are supported by substantial evidence.¹ The “substantial evidence” standard is considered very deferential in contrast to the *de novo* standard. A court may remand the case back for SSA (not the court) to consider new evidence but only if it is new, material, and there is good cause for the failure to submit it in the prior administrative proceedings.² The courts have been strict in applying this provision and such remands occur very infrequently. The strict rules in the July 27th proposal are certainly exacerbated by the limitations at the federal court level regarding new evidence.

[Submissions for the record follow:]

New York, New York 10024
October 4, 2005

The Honorable Wally Herger
Chairman, Subcommittee on Human Resources

The Honorable Jim McCrery
Chairman, Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairmen,

Thank you for the opportunity to submit this letter regarding the Commissioner of Social Security’s proposed regulations regarding the administrative review process for adjudicating initial disability claims for the record of the above hearing. My name is Robin J. Arzt. I am an Administrative Law Judge (“ALJ”) who has been hearing Social Security disability and Medicare cases for over eleven years at the Office of Hearings and Appeals (“OHA”) of the Social Security Administration (“SSA”) in New York, New York, and formerly in the Bronx, New York.

This letter is presented in my individual capacity. My position as an Administrative Law Judge with the Social Security Administration is stated in this letter for identification purposes only. This letter was written in my private capacity and without the use of Federal Government resources or federal work time. No official support or endorsement by the Social Security Administration or the United States is or should be inferred. The views expressed in this letter are mine and do not necessarily represent the views of the Social Security Administration or the United States.

I. INTRODUCTION

The Commissioner has published wide-ranging proposed regulations to redesign the disability determination process from the initial determination stage through the final administrative decision step. The Commissioner’s bold proposals and inclusive process are to be appreciated.

The Commissioner has proposed, among other things, to (1) replace the reconsidered determination with a review by a federal Reviewing Official (“RO”), (2) retain a claimant’s due process right to a *de novo* administrative hearing before an ALJ upon appeal from an RO’s decision, and (3) replace the Appeals Council with a Decision Review Board (the “Board”) that will include ALJs and Administrative Appeals Judges (“AAJs”). ALJs are independent decisionmakers who are appointed pursuant to the Administrative Procedure Act (“APA”).¹ AAJs are SSA employees who currently serve on the SSA Appeals Council and are subordinate employees because of the lack of any statutory protections of their decisional independence.

It is excellent that the Commissioner is proposing both the retention of the claimants’ due process right to a *de novo* administrative hearing before an ALJ upon appeal from an RO’s decision and inclusion of ALJs in the final administrative step after the ALJ hearing and decision. The Commissioner’s recognition that the APA provisions were enacted for the benefit of the claimants and to enhance the dis-

¹ 42 U.S.C. § 405(g).

² This is known as a “sentence six” remand because it is authorized by the sixth sentence in 42 U.S.C. § 405(g).

¹⁵ U.S.C. § 3105.

ability process should be commended. The Commissioner made her support of the ALJs and their role in the disability process clear during her September 25, 2003, testimony before the Subcommittee on Social Security.² The Commissioner also reported that ALJ case “productivity rates [in FY 2003] were the highest in history” during her February 26, 2004, testimony before the Subcommittee on Social Security.³ The SSA ALJs again set an all time productivity record in Fiscal Year 2005, with a daily ALJ disposition rate of about 2.46 cases per day.⁴

Only proposed regulations that bear upon the structure and due process of the SSA appellate administrative levels, including the decisional independence of ALJs and AAJs, are commented upon in this letter:

In section A(1) below, I comment on the features of the Commissioner’s proposed regulations regarding the final administrative review step: the replacement of the Appeals Council with the Board. (See p. 2). I offer information in section A(2) regarding **my ALJ appellate panel proposal that was recommended for use within OHA to replace the Appeals Council by a March 2002 report commissioned by the Social Security Advisory Board (“SSAB”)**⁵ **to explain the many demonstrated benefits that a fully developed appellate panel system with a claimant’s right of appeal will bring to (1) increase consistency between the final SSA administrative decision and initial court decision, (2) increase decision timeliness, and (3) decrease the number of appeals to the District Courts, rather than increase court appeals as would the Board as it currently is proposed.** (See p. 4). Finally, in section A(3), I suggest modifications to the Commissioner’s proposed regulations that would let Social Security claimants, SSA, the federal courts, and the American public reap the benefits of an ALJ appellate panel process, including increased accuracy and timeliness of decisions, fewer court appeals, and assurance of the decisional independence of the ALJs and AAJs. (See p. 7).

In section B, I comment on the Commissioner’s proposed regulations regarding the RO and treatment of an RO’s decision in an ALJ’s decision. I also suggest modifications to the Commissioner’s proposed regulations that would increase the accuracy of decisions between the RO and ALJ steps and reduce appeals from the RO decisions without compromising ALJ decisional independence. Among other things, I respectfully suggest that the Commissioner state in the regulations that an ALJ is not required to give any legal deference or any weight to an RO’s decision, and that **a more effective way to increase the consistency of decisionmaking between the RO and ALJ decision levels would be to require that the RO use the same legal standards for determining disability as those by which the ALJs are bound.** (See p. 8).

In section C, I comment and make suggestions on the administrative placement of the RO and Board within SSA to ensure separate chains of authority to the Commissioner for the ALJs from agency initial decisionmakers in accordance with the APA separation of functions doctrine. (See p. 10).

A. Replacement of the Appeals Council with a Decision Review Board

1. The Proposed Regulations

The Commissioner’s proposed regulations gradually would replace the Appeals Council with the Board,⁶ which would consist of ALJs and AAJs.⁷

The proposed regulations eliminate a claimant’s right to request administrative review of an adverse ALJ’s disability benefits claim decision under Title II and XVI of the Social Security Act: “You may not appeal an [ALJ’s] decision to the Board.”⁸

The proposed regulations do not specify how many members that the Board would have, although the Supplementary Information states that “[w]e believe that the . . . functions . . . performed by the Appeals Council can be performed more effec-

²*Hearing on the Social Security Administration’s Management of the Office of Hearings and Appeals Before the House Subcommittee on Social Security of the Committee on Ways and Means*, 108th Cong. (1st Sess., September 25, 2003) (statement of Hon. Jo Anne B. Barnhart, SSA Commissioner).

³*Hearing on the Social Security Administration’s Budget Delivery Service Plan Before the House Subcommittee on Social Security of the Committee on Ways and Means*, 108th Cong. (2nd Sess., February 26, 2004) (statement of Hon. Jo Anne B. Barnhart, SSA Commissioner).

⁴Memorandum from A. Jacy Thurmond, Jr., Associate Commissioner of SSA OHA, *Thank You, OHA—INFORMATION* (October 3, 2005) [hereinafter *Thurmond Memo*] (on file with author).

⁵See discussion *infra* text at n. 26.

⁶Proposed 20 C.F.R. § 405.405.

⁷Proposed 20 C.F.R. § 405.405(a).

⁸Proposed 20 C.F.R. § 405.405(b). See also, proposed 20 C.F.R. § 405.1(a).

tively by a smaller review body.”⁹ Given that the Appeals Council has only about 27 adjudicators and has been plagued for decades by case backlogs and poor decision quality directly attributable at least in part to its small size despite its support staff of 800, I respectfully submit that an even smaller Board will not be able to keep up with the caseload and enhance decision quality.

The Board would evaluate and review “certain” ALJ decisions selected by the agency before the decisions are effectuated¹⁰ and review ALJ decisions selected by the agency after the decisions have been effectuated in order “to study [the agency’s] disability determination process.”¹¹ However, if an ALJ declines a claimant’s request to vacate the ALJ’s order dismissing the claimant’s request for a hearing, the claimant has a right to request administrative review of the ALJ’s dismissal order by the Board as the final step in the administrative review process.¹² The “Supplementary Information” preamble to the Commissioner’s proposed regulations states that a claimant “will continue to have the right to seek further administrative review of any [ALJ] decision pertaining to [the claimant’s] nondisability case,”¹³ since the proposed regulations pertain only to disability cases.¹⁴

The Board may elect to review decisions that are favorable or unfavorable to the claimant. The Board may use “random sampling, . . . specific claim characteristics, a combination of these two methods, or other methods to select claims for review,” but may not review claims based on an ALJ’s identity.¹⁵ The Commissioner described another method to select claims for review in the Supplementary Information: “We intend to screen every [ALJ] decision, using computer-based predictive screening tools and individual case record examination performed by skilled reviewers, to identify cases for Decision Review Board review.”¹⁶ The proposed regulations do not include a provision that the Board will “generally select and review an equal share of each type of case [favorable and unfavorable ALJ decisions],” as is stated in the Supplementary Information.¹⁷ The knowledge of such detailed and wide ranging agency scrutiny of ALJ decisions and, soon, the knowledge of the case profiles and characteristics identified by the agency that are more likely to result in Board review, will chill the independence of the ALJ decision making process.

The Commissioner presents the Board’s role for disability and nondisability cases as a quality review process, not the final administrative appellate step. As is stated in the Supplementary Information, “We envision that the Decision Review Board will help us promote the consistency and efficiency of the adjudicatory process by promptly identifying and reviewing, and possibly readjudicating, those [ALJ] decisions that are the most likely to be erroneous.”¹⁸

However, I respectfully submit that SSA effectively is providing itself with an administrative appeal of the ALJ’s substantive disability decisions that the claimant no longer will have. The Board would be able to affirm, modify, or reverse an ALJ’s decision or remand a case to the ALJ for further action and decision.¹⁹ The Board would apply a “substantial evidence” standard in reviewing the findings of fact made by an ALJ and would review *de novo* the application of law.²⁰ The Board’s decision becomes the final decision of the Commissioner when it reviews a case. But if the Board does not complete its action on a case within 90 days of the date the claimant receives a notice that the Board is reviewing the case, or the Board does not review the case, then the ALJ’s decision becomes the Commissioner’s final decision.²¹ A claimant would have the right to file an action in federal district court within 60 days of the date the Commissioner’s decision becomes final and judicially reviewable.²²

Since a Board decision becomes the final decision of the Commissioner, I respectfully submit that the quality review step proposed by the Commissioner to be taken by SSA to the proposed Board is an appeal, not only quality review. Quality review usually involves a post mortem review of closed cases.

⁹ 70 Fed. Reg. 43598 (July 27, 2005).

¹⁰ Proposed 20 C.F.R. § 405.405(b).

¹¹ Proposed 20 C.F.R. § 405.405(d).

¹² Proposed 20 C.F.R. §§ 405.381–405.383, 405.405(c).

¹³ 70 Fed. Reg. 43598 (July 27, 2005).

¹⁴ Proposed 20 C.F.R. § 405.1(a).

¹⁵ Proposed 20 C.F.R. § 405.410.

¹⁶ 70 Fed. Reg. 43598 (July 27, 2005).

¹⁷ 70 Fed. Reg. 43598 (July 27, 2005).

¹⁸ 70 Fed. Reg. 43602 (July 27, 2005).

¹⁹ 20 C.F.R. §§ 405.405(b), 405.440.

²⁰ 20 C.F.R. § 405.440.

²¹ 20 C.F.R. §§ 405.372, 405.415, 405.420, 405.450.

²² 20 C.F.R. § 405.501.

Permitting SSA appellate review of an ALJ's decision by the Board, which is relatively easier, faster and lower cost than a District Court appeal, but limiting the claimants to only a District Court review of an adverse ALJ decision, raises substantial fairness and due process issues. The omission of the claimants' right to access the final administrative appellate step to review ALJs' decisions increases the risk that erroneous denials of benefits will not be corrected because some claimants, particularly *pro se* claimants, who would be able to pursue a relatively simple administrative appeal will not have the wherewithal to bear the additional procedural and financial burdens of prosecuting a court appeal.

In addition, without a claimant's right to appeal an adverse ALJ decision to the Board, the District Courts will be inundated with appeals from the individual ALJ decisions. There are over 90,000 claimant appeals to the Appeals Council per year,²³ which would be a burden for the District Courts. Recent Congressional testimony on behalf of the Judicial Conference of the United States (1) stated its opposition to "the elimination of a claimant's right to request review of an administrative law judge's adverse decision by the Appeals Council, or another administrative reviewing unit with comparable authority, prior to seeking relief in federal district court," and (2) cogently explained the need for a specialized administrative tribunal to which a Social Security disability benefits claimant can appeal an ALJ's decision in the context of the recent adverse experience of skyrocketing numbers of immigration case appeals to the courts since the "streamlining" of the Board of Immigration Appeals decisionmaking procedures.²⁴

²³The Appeals Council disposed of over 94,000 during Fiscal Year 2005, which ended in September 2005. *Thurmond Memo*, *supra* note 4.

²⁴The Judicial Conference testimony stated as follows:

At its March 2005 session, the Judicial Conference of the United States, the policymaking body for the federal judiciary, determined to "support efforts to improve the efficiency and effectiveness of the process by which the Social Security Administration considers Disability Insurance and Supplemental Security Income claims, but oppose the elimination of a claimant's right to request review of an administrative law judge's adverse decision by the Appeals Council, or another administrative reviewing unit with comparable authority, prior to seeking relief in federal district court." *Report of the Proceedings of the Judicial Conference of the United States*, March 2005, pp. 18–19. . . .

We recognize that SSA has stated that the Appeals Council adds processing time, that it generally supports the ALJ decision, and that it fails to provide meaningful guidance to ALJs when it disagrees. The judiciary, however, believes that the proposed acceleration of district court review of disability claim denials may result in more costs and further delays for claimants because it merely shifts the time for considering such claims from the administrative process to the courts. It could also greatly expand the number of appeals to the federal courts.

Based on information provided by SSA, the ability of claimants to request review by the Appeals Council appears to provide a helpful screening function today. Between October 2003 and September 2004 (FY 2004), SSA reports that the Appeals Council received 92,540 requests for review. Information previously received from SSA suggested that 2% of claims annually are allowed outright by the Appeals Council and 25% are remanded to an ALJ (which often results in allowances to claimants). Thus, the right to request administrative appellate review also appears to result in an award of benefits to a significant number of claimants, without the need for further review by the federal courts.

The Administrative Office of the U.S. Courts reports that during FY 2004 there were 14,944 actions filed in the U.S. district courts seeking judicial review of Disability Insurance and Supplemental Security Income claims following a final decision of the Appeals Council. This amount is a relatively modest percentage of the 92,540 requests for review presented to the Appeals Council. While the judiciary recognizes that several factors might explain why the remainder of the claimants choose [sic] not to seek review in federal court, the existence of a right to seek administrative appellate review appears to result in a large majority of claimants not seeking judicial review following receipt of the Appeals Council's final decision.

The Judicial Conference believes that preserving the right to request review before an administrative appellate body should continue to be a precondition to federal judicial review. Notwithstanding SSA's position that the proposed changes to the disability claims process will reduce the number of claimants who are dissatisfied with the agency's decision, substituting immediate access to the district courts prior to the right to request final administrative appellate review has significant caseload ramifications for the federal courts. [Fnote 3 text.] A possible analogy is the judiciary's experience after the Department of Justice implemented new decisionmaking procedures for the Board of Immigration Appeals, which serves as the final review step for administrative consideration of alien removal and deportation cases. These "streamlining" efforts included allowing certain decisions to be made without opinions and permitting summary dismissals. As a result of these efforts, immigration appeals increased nationwide by 232% between 2001 and 2004 (for 12-month periods ending June 30). The Second and Ninth Circuit Courts of Appeals saw immigration appeals increase during this period by 1,396% and 401%, respectively.

The Appeals Council and the proposed Board are specialized tribunals dedicated to reviewing ALJ decisions. The district courts are no less dedicated, but they have diverse responsibilities

Continued

2. The Need for a Fully Developed ALJ Appellate Panel System for SSA's Final Administrative Review Step

I am gratified that the Commissioner is proposing to include ALJs as members of the proposed Board that would replace the Appeals Council. As is stated in the Supplementary Information, the Commissioner's preliminary proposals regarding the disability determination process that she first presented during her September 25, 2003, testimony before the Subcommittee on Social Security included replacing the Appeals Council with a Centralized Quality Control Review ("CQCR") function within SSA with the final step of administrative review being by "Oversight Panels" of two ALJs and one AAJ upon referral of cases by CQCR staff.²⁵ The appellate panel concept is not expressly included in the Commissioner's proposed regulations, but also is not ruled out, since the proposed regulations do not specify whether one or more Board members will review an ALJ's decision. I also am gratified that the Commissioner has been considering the appellate panel concept.

The Commissioner's proposal to introduce ALJs at the final level of administrative review and have them, with the AAJs, decide appeals from individual ALJ decisions, and her preliminary proposal to have ALJs and AAJs make decisions in panels of three, borrowed from my proposal for local appellate panels of three ALJs as the final step to replace the Appeals Council in the Social Security disability claims administrative process. The appellate panel proposal is part of a detailed paper that I authored for the Association of Administrative Law Judges ("AALJ") and, more recently, a law review article, that suggests an ALJ-administered independent adjudication agency for Social Security Act benefits cases with the exclusive jurisdiction to make the final administrative decisions of Social Security Act Title II, XVI and XVIII benefits claims.²⁶

A March 2002 report commissioned by the SSAB favorably and extensively commented upon my proposal for local ALJ appellate panels to replace the Appeals Council and recommended its use within SSA OHA.²⁷ (It is the SSAB report that apparently brought the ALJ appellate panel proposal to the Commissioner's attention, given the Commissioner's reference to one of its authors, Professor Jeffrey Lubbers, as a source during her September 25, 2003, testimony before the Subcommittee on Social Security.)

Under my appellate panel proposal, the claimants and SSA would have a right of appeal of an individual ALJ's decision to a local appellate panel staffed by ALJs that would consist of three ALJs who would review the cases regionally or locally. The ALJ appellate panels would be akin to the United States Bankruptcy Court appellate panels ("BAPs").²⁸ A Social Security ALJ Appellate Panel Service would be established in each region composed of ALJs appointed in each region for a period of time to hear and determine appeals taken from ALJ decisions issued pursuant to 42 U.S.C. §§ 405(b), 1383(c), and 1395(b). Appointed ALJs may be reappointed. An appeal would be assigned to a panel of three members of a Social Security Ap-

that make them less suitable for initially reviewing the current 90,000 disability claims of which approximately 75,000 are acted on by the Appeals Council without any federal judicial involvement. Therefore, the federal judiciary would urge that SSA revise the proposed regulations to preserve the present right of claimants to request review of an ALJ decision by an administrative reviewing entity.

Joint Hearing on the Commissioner of Social Security's Proposed Improvements to the Disability Determination Process before the House Subcommittees on Human Resources and Social Security of the Committee on Ways and Means, 109th Cong. (1st Sess., September 27, 2005) (statement of Hon. Howard D. McKibben, Chair, Judicial Conference Committee, Federal-State Jurisdiction, Administrative Office of the U.S. Courts).

²⁵ 70 Fed. Reg. 43592 (July 27, 2005).

²⁶ The detailed adjudication agency proposal is embodied in Robin J. Arzt, "Recommendations for a New Independent Adjudication Agency to Make the Final Administrative Adjudications of Social Security Act Benefits Claims," 23 J. Nat'l Ass'n Admin. L. Judges 267-386 (Fall 2003) and, originally, in an AALJ policy position paper, which are available upon request. The paper was adopted as a policy position by AALJ, which represents the ALJs who work for SSA and the Civil Remedies Division of the DHHS Departmental Appeals Board. A summary of the adjudication agency proposal was submitted to the Subcommittee on Social Security as AALJ's statement for the record of the June 28, 2001, hearing on Social Security Disability Programs' Challenges and Opportunities. My comments on the Commissioner's preliminary proposals to improve the disability determination process were submitted to the Subcommittees as my statement for the record of the September 30, 2004, joint hearing on the Commissioner of Social Security's Proposal to Improve the Disability Process.

²⁷ Paul Verkuil and Jeffrey Lubbers, *Alternative Approaches to Judicial Review of Social Security Disability Cases* 19-21, 56, 63-68 (March 2002), available at www.ssab.gov/verkuillubbers.pdf. This article includes an exhaustive survey of the many recommendations over the last 20 years to abolish the Appeals Council and suggested replacement mechanisms, including the proposal that I drafted for AALJ.

²⁸ *Id.* at 356-361.

pellate Panel Service, except that a member of such service may not hear an appeal originating in the hearing office that is the member's permanent duty station or the hearing office where the member is on a temporary detail assignment. A sufficient number of such panels would be designated so that appeals may be heard and disposed of expeditiously. Multi-region panels may be established to meet the needs of small regions.²⁹

The ALJ appellate panels would be required to apply a "substantial evidence" standard in reviewing an individual ALJ's decision. Another issue to consider is whether the ALJ appellate panel decisions should be given precedential value by the individual ALJs sitting in either the hearing office or entire region where the appeal originated.³⁰ However, the policymaking authority of the agency cannot be usurped.

The ALJ appellate panel proposal is modeled in principle on the Bankruptcy Court Appellate Panel statute,³¹ but was modified to make the ALJ appellate panels process mandatory for Social Security Act benefits cases, rather than elective by the parties as it is for the BAPs process.³²

I adapted the BAPs model for SSA benefits case use because the Bankruptcy Court system is another nationwide network of tribunals that hears a high volume of cases in a specialized area that are generated mostly from individual petitioners. There are ninety-two Bankruptcy Courts situated in proximity to the District Courts.³³ There are about 140 Social Security hearing offices.³⁴ Over 1,600,000 cases were filed in Bankruptcy Court in 2004.³⁵ SSA's ALJs disposed of over 604,000 cases in Fiscal Year 2005, which concluded in September 2005.³⁶ Social Security claimants and SSA can benefit from the use of an appellate system that has proven to work on a large scale.

Based upon the BAPs experience, the ALJ appellate panel model (1) is an appellate system that can handle a large caseload, (2) results in higher quality decisions because of expertise,³⁷ (3) results in substantially fewer appeals to the courts³⁸ and

²⁹ *Id.*

³⁰ Thalia L. Downing Carroll, *Why Practicality Should Trump Technicality: A Brief Argument for the Precedential Value of Bankruptcy Appellate Panel Decisions*, 33 Creighton L. Rev. 565, 571-77 (2000).

³¹ 28 U.S.C. § 158 (1993).

³² The Bankruptcy Court Appellate Panels process was made permissive, not mandatory, and thus is not used in all Circuits, because of a Constitutional issue whether the use of the Panels is an improper delegation of Article III court jurisdiction over private rights in bankruptcy from the District Courts. Bankruptcy Court Appellate Panel review is a substitute for District Court review only upon all parties' consent and appeals go directly to the regional Circuit Courts of Appeals. Because there is no Constitutional jurisdiction issue for administrative cases involving entitlement to public rights that were created by statute, such as administrative determinations of entitlement to Social Security Act benefits, the Bankruptcy Court Appellate Panel model may be modified to make it mandatory for Social Security Act benefits cases. Downing Carroll, *supra* note 30, at 565; Hon. Barbara B. Crabb, *In Defense of Direct Appeals: A Further Reply to Professor Chemerinsky*, 71 Am. Bankr. L.J. 137 (1997); Tisha Morris, *The Establishment of Bankruptcy Panels Under the Bankruptcy Reform Act of 1994: Historical Background and Sixth Circuit Analysis*, 26 U. Memphis L. Rev. 1501 (1996); Thomas A. Wiseman, Jr., *The Case Against Bankruptcy Appellate Panels*, 4 Geo. Mason L. Rev. 1 (1995).

³³ 28 U.S.C. § 152 (2003).

³⁴ See Social Security Online, available at http://ftp.ssa.gov/oha/hearing_process.html.

³⁵ *Judicial Facts and Figures of the United States Courts: 1988-2004*, Table 5.1, available at <http://www.uscourts.gov/judicialfactsfigures/table5.01.pdf>.

³⁶ Thurmond Memo, *supra* note 4.

³⁷ A survey of bankruptcy practitioners revealed that two-thirds of them believed that the appellate panel decisions were "better products" than District Court decisions. Wiseman, *supra* note 32, at 7.

³⁸ Annual data show that **a far smaller percentage of bankruptcy appeals are taken to the circuit level from BAP decisions than from District Court decisions.**

During the year that ended on June 30, 2003, only about 11.6% of BAP decisions were appealed to the Circuits compared to 27.9% of the District Court decisions during the year that ended on June 30, 2003.

There were 1,071 appeals taken from individual Bankruptcy Court judges' decisions to the BAPs and only 124 BAP decisions appealed to a Circuit Court. However, there were 2,616 appeals taken from individual Bankruptcy Court judges' decisions to a District Court Judge and 729 District Court decisions appealed to a Circuit Court.

During the year that ended on June 30, 2004, only about 15.8% of BAP decisions were appealed to the Circuits compared to 26.1% of the District Court decisions during the year that ended on June 30, 2004. There were 1,010 appeals taken from individual Bankruptcy Court judges' decisions to the BAPs and only 160 BAP decisions appealed to a Circuit Court. However, there were 2,807 appeals taken from individual Bankruptcy Court judges' decisions to a District Court Judge and 733 District Court decisions appealed to a Circuit Court.

Table B-23, *U.S. Bankruptcy Appellate Activity by Circuit and District for Matters Filed or Terminated during the Twelve Month Periods Ended June 30, 2003, and June 30, 2004*, provided

Continued

a substantially lower reversal rate by the courts³⁹ because of the bar's and courts' confidence in the high quality of the decisions that results from a higher degree of decision accuracy from three expert decisionmakers working together,⁴⁰ (4) results in a substantially reduced federal court caseload, (5) results in a shorter disposition time⁴¹ because the large pool of about 1,200 ALJs permits the timely determination of appeals that cannot take place with a small body such as the SSA Appeals Council or the proposed Board, and (6) affords the claimants access to a local appellate process.⁴² The opportunity for appellate work also increases judges' morale and is viewed by judges as an honor and an opportunity to "improve judicial service to the litigants."⁴³

Therefore, by increasing the accuracy of the final SSA administrative decisions and thus reducing the need for appeals to the District Courts, the ALJ appellate panel system would be superior to the current SSA Appeals Council or proposed small Board in providing timely, high quality decisions and service for the claimants.

3. Proposed Modifications to the Proposed Regulations Regarding the Decision Review Board

As is stated above, the proposed regulations neither permit a claimant to appeal an individual adverse ALJ's decision to the proposed Board nor include a reference to using ALJ appellate panels within the proposed Board. These are major departures from the ALJ appellate panel proposal that would eliminate many of the benefits of a BAP type process, including much greater decisional consistency between the final administrative and initial court levels and fewer appeals to the federal courts. The claimants must have a right to appeal to the Board in order for the claimants, SSA, the courts, and the American public to receive the many demonstrated benefits to the Social Security Act claims process of an appellate panel

to the author by the Statistics Office of the Administrative Office of the United States Courts (on file with author).

³⁹Annual data show **that a markedly smaller percentage of BAP bankruptcy decisions were reversed on appeal by the Circuit Courts than the District Court bankruptcy decisions**, based on the Circuit Court appeals that were terminated on the merits during the years that ended on June 30, 2002, June 30, 2003, and June 30, 2004. In addition, there was only one remand of a BAP decision during the entire three year period, compared to 24 remands of the District Court decisions. Therefore, remands of BAP decisions by the Circuit Court are rare.

During the year that ended on June 30, 2002, the percent of BAP decision reversals was only 55.5% of the percent of the District Court decision reversals during the year that ended on June 30, 2002. There were 359 terminations of appeals from District Court bankruptcy issue decisions on the merits by the Circuit Courts, of which 12.8% (46) were reversed and 1.9% (7) were remanded. There were 112 terminations of appeals from BAP decisions on the merits by the Circuit Courts, of which only 7.1% (8) were reversed and none were remanded.

During the year that ended on June 30, 2003, the percent of BAP decision reversals was only 77.4% of the percent of the District Court decision reversals during the year that ended on June 30, 2003. There were 393 terminations of appeals from District Court bankruptcy issue decisions on the merits by the Circuit Courts, of which 13.7% (54) were reversed and 1.8% (7) were remanded. There were 85 terminations of appeals from BAP decisions on the merits by the Circuit Courts, of which only 10.6% (9) were reversed and 1.2% (1) was remanded.

During the year that ended on June 30, 2004, the percent of BAP decision reversals was only 62.45% of the percent of the District Court decision reversals during the year that ended on June 30, 2004. There were 359 terminations of appeals from District Court bankruptcy issue decisions on the merits by the Circuit Courts, of which 18.1 (65) were reversed and 2.8% (10) were remanded. There were 62 terminations of appeals from BAP decisions on the merits by the Circuit Courts, of which only 11.3% (7) were reversed and none were remanded.

Table B-5, *U.S. Courts of Appeals: Appeals Terminated on the Merits, by Circuit during the Twelve Month Periods Ended June 30, 2002, June 30, 2003, and June 30, 2004*, BAP/District Court statistical breakdown created for and provided to the author by the Statistics Office of the Administrative Office of the United States Courts (on file with author).

⁴⁰Appellate panel work fosters the development of expertise by the panel members, which leads to better decisions. Morris, *supra* note 17, at 1509 (citing, *Final Report of the Federal Courts Study Committee*, 74-75 (1990)).

⁴¹Annual data regarding the disposition time of the appeals heard by the BAPs shows that the median disposition time from the filing of the notice of appeal through final disposition was 8.4 months during the year that ended on June 30, 2002, 8.5 months during the year that ended on June 30, 2003, and 8.9 months during the year that ended on June 30, 2004. Table B-14, *U.S. Bankruptcy Appellate Panels Median Time Intervals in Cases Terminated after Hearing or Submission during the Twelve Month Periods Ended June 30, 2002, June 30, 2003, and June 30, 2004*, provided to the author by the Statistics Office of the Administrative Office of the United States Courts (on file with author).

⁴²See discussion in *Id.* at 356-361.

⁴³Morris, *supra* note 32, at 1509 (quoting, Federal Courts Study Commission, *Working Papers and Subcommittee Reports*, Vol. 1, 364 (1990)).

process, including faster appellate decisions, increased consistency between the final SSA administrative decisions and initial court decisions, and fewer federal court appeals.

Another departure from the ALJ appellate panel proposal is the use of AAJs, a subordinate SSA employee with no protections for decisional independence, as members of the proposed Board. Also, the proposed regulations do not state how many members the Board will have, or whether the Board will be centralized in one location, or located regionally or locally for better access to the claimants. Finally, although the Commissioner states in the Supplementary Information that Board membership will rotate among the ALJs and AAJs and their terms of service will be staggered,⁴⁴ rotation and term staggering are not provided for in the proposed regulations.

So that Social Security claimants, SSA, the federal courts, and the American public reap the benefits of a Bankruptcy Court appellate panel-style process, I respectfully suggest that the Commissioner consider modifying her Decision Review Board proposal and issue regulations that provide that

(1) A Social Security Act benefits claimant has a right of appeal of an adverse individual ALJ's decision to the Board.

(2) The Board is the final step of administrative review that must be taken by a Social Security disability benefits claimant in order to seek judicial review of the Commissioner's decision in the claimant's case.

(3) A sufficient number of Board members will be appointed so that appeals may be heard and disposed of expeditiously.

(4) The Board members will hear appeals in panels of three members.

(5) A sufficient number of panels of three Board members will be designated so that appeals may be heard and disposed of expeditiously.

(6) The Board and appellate panels will be constituted regionally or locally for claimant access.

(7) The Board will be constituted from the full nationwide SSA ALJ workforce to ensure nationwide ALJ participation.

(8) There will be rotation of service as members of the Board among the ALJs in the SSA ALJ workforce, and staggering of their terms of service, to ensure that the members have recent field experience with hearing and deciding cases.

(9) Only independent decisionmakers may serve as Board members, meaning ALJs who have the protections of the APA that have been put in place for the benefit of the claimants. The 27 AAJs from the Appeals Council may be afforded protections for decisional independence for the benefit of the claimants by grandfathering the AAJs into ALJ status, as was done in the 1970s for the administrative judges who heard SSI cases.⁴⁵

(10) In the event that AAJs are not grandfathered into ALJ status, no more than one of each Board appellate panel will be an AAJ because of the AAJs' lack of protections for decisional independence.

(11) A Board member may not hear an appeal originating in the hearing office that is the member's permanent duty station or the hearing office where the member is on a temporary detail assignment.

All of the suggested modifications, other than those pertaining to the AAJs' status, are the elements of the BAPs that have made that process a demonstrated success.

An ALJ appellate panel system should result in faster and much higher quality decisions than those produced by the Appeals Council or would be produced by the proposed small Board, but only if it functions as an appellate step for both the claimants and SSA. A fully developed ALJ appellate panel process greatly will enhance the consistency and quality of outcome between the final administrative step and District Court step, and thus reduce the number of appeals to the courts, just as it has between the BAPs and next level of judicial review.

⁴⁴ 70 Fed. Reg. 43598 (July 27, 2005).

⁴⁵ "In 1977, Congress enacted Public Law Number 95-216, containing a section entitled Appointment of Hearing Examiners, which deemed the temporary ALJs to be permanent ALJs appointed pursuant to 5 U.S.C. § 3105 of the APA." Robin J. Arzt, *Adjudications by Administrative Law Judges Pursuant to the Social Security Act are Adjudications Pursuant to the Administrative Procedure Act*, 22 J. Nat'l Ass'n Admin. L. Judges 279, 304 & n. 96 (Fall 2002) (citing, Social Security Amendments of 1977, Pub. L. No. 95-216, 91 Stat. 1509, 1559 (1977)).

B. The Reviewing Official and Treatment of a Reviewing Official's Decision in an ALJ's Decision

The Commissioner has proposed the creation of an RO, who would be an attorney employed by SSA who would review a claimant's case upon the claimant's appeal from an adverse initial determination by SSA of a disability benefits application.⁴⁶ The RO would have authority to reverse, modify, affirm or remand an initial determination.⁴⁷ The RO review would replace the State agency (DDS) reconsidered determination step.⁴⁸ If an RO does not fully allow a disability claim, the claimant has a right to appeal for a *de novo* hearing before an ALJ appointed pursuant to the APA.⁴⁹

The Supplemental Information states that the proposed regulations provide that the RO's review is based only on the written record and the RO will not conduct a hearing or meet with a claimant,⁵⁰ but the regulations are silent on this issue. I respectfully submit that the proposed regulation regarding the procedures before an RO⁵¹ should expressly state that the RO will not conduct a hearing or meet with a claimant.

The proposed regulations require that an ALJ's written decision "will articulate . . . the specific reasons for the decision, including an explanation as to why the [ALJ] agrees or disagrees with the rationale articulated in the [RO's] decision."⁵² If an ALJ grants a fully favorable decision by use of an oral bench decision at the hearing, after the hearing "we will send you a written decision that explains why the [ALJ] agrees or disagrees with the rationale articulated in the [RO's] decision. . . ."⁵³ The Commissioner states in the Supplementary Information that the purpose of this new requirement is only to help the agency provide the ROs with information from ALJs to improve the quality of the ROs' decisions in terms of articulation, consistency with program rules and developing a complete record, and that

[ALJs] will continue to hold *de novo* hearings and issue decisions based on all the evidence presented. They will not be required to give any legal deference or particular weight to the determinations previously made by the State agency or by the reviewing official. . . .

We do not intend that this new responsibility will constrain an [ALJ's] independent decisionmaking authority in any manner. Each [ALJ] will continue to issue written decisions based on his or her independent evaluation and consideration of the evidence offered at the hearing or otherwise included in the record.⁵⁴

However, the proposed regulations do not say that an ALJ is not required to give any legal deference or any weight to an RO's decision. The proposed regulations also do not say that an ALJ's explanation of why the ALJ agrees or disagrees with an RO's decision rationale is not a component of the ALJ's decision that is necessary for a legally sufficient decision.

Therefore, the proposed requirement that an ALJ provide a significant exposition about why the ALJ agrees or disagrees with an RO's decision in every disability case decision may incorrectly be interpreted as a requirement that the RO's assessment is entitled to some degree of deference or weight. Moreover, any specific regulatory requirement that the ALJ address the RO's decision would create the potential for erroneous arguments on appeal and appellate findings that an ALJ's decision is deficient for a failure to adequately address, defer or give weight to the RO's decision.

Therefore, despite the Commissioner's stated good intentions for the proposed requirement, the mandated explanation of why an ALJ agrees or disagrees with the RO's decision does impinge upon the *de novo*,⁵⁵ independent nature of the ALJ's hearing and decision process. Holding a *de novo* hearing means to hear a matter anew, as if it is being heard for the first time and no decision previously was rendered.⁵⁶ *De novo* review is "independent" review.⁵⁷ Accordingly, the proposed requirement will foster a perception of agency pressure to give an improper deference

⁴⁶ Proposed 20 C.F.R. §§ 405.5, 405.201, Fed. Reg. 43595 (July 27, 2005).

⁴⁷ Proposed 20 C.F.R. § 405.220.

⁴⁸ Proposed 20 C.F.R. § 405.220, 70 Fed. Reg. 43595 (July 27, 2005).

⁴⁹ Proposed 20 C.F.R. §§ 405.5, 405.305.

⁵⁰ 70 Fed. Reg. 43595, 43601 (July 27, 2005).

⁵¹ Proposed 20 C.F.R. § 405.215.

⁵² Proposed 20 C.F.R. § 405.370(a).

⁵³ Proposed 20 C.F.R. § 405.370(b).

⁵⁴ 70 Fed. Reg. 43596, 43602 (July 27, 2005).

⁵⁵ The ALJ level of review is a *de novo* review. *Mathews v. Eldridge*, 424 U.S. 319, 339 n. 21 (1976).

⁵⁶ *Ness v. Commissioner*, 954 F.2d 1495, 1497 (9th Cir. 1992).

⁵⁷ *Premier Communications Network, Inc. v. Fuentes*, 880 F.2d 1096, 1102 (9th Cir. 1989).

or weight to the RO decisions among claimants and their representatives that likely will result in an increase in the number of appeals from ALJ denials of benefits.

The standard for a sufficient ALJ decision on appeal is whether there is substantial evidence in the record to support the decision, not whether the ALJ adequately addressed or deferred to the outcome or contents of a prior decisionmaker's decision.⁵⁸ The APA and Social Security Act already require that an ALJ discuss the evidence in rendering the ALJ's decision on a disability benefits claim without reference to the outcome or contents of the agency's prior determinations. The APA requires that all agency administrative decisions, including ALJ "decisions . . . shall include a statement of (A) findings and conclusions, and the reasons or basis therefor, on all the material issues of fact, law, or discretion presented on the record; and (B) the appropriate rule, order, sanction, relief, or denial thereof."⁵⁹ Title II of the Social Security Act sets forth the elements to be included in agency administrative decisions regarding eligibility for disability benefits:

Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, **setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based.** Upon request by any such individual or upon request by a wife, divorced wife, surviving divorced mother, surviving divorced father, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision.⁶⁰

Decisions regarding supplemental security income eligibility under Title XVI of the Social Security Act must include the same elements as decisions regarding Title II disability eligibility.⁶¹

To preserve the independent, *de novo* nature of the ALJ hearing and decision, I respectfully suggest that the Commissioner state in the regulations that an ALJ is not required to give any legal deference or any weight to an RO's decision. I also respectfully suggest that the Commissioner consider omitting the proposed requirement that an ALJ must address the RO's decision from her proposed regulations. If the Commissioner decides to promulgate the requirement that an ALJ must address the RO's decision, I respectfully suggest that the Commissioner also state in the regulations that an ALJ's explanation of why the ALJ agrees or disagrees with an RO's decision rationale is not a component of the ALJ's decision that is necessary for a legally sufficient decision, and that an ALJ's statements about an RO's decision, or omission of such statements, may not serve as a basis for an appeal or review of an ALJ's decision.

That the Commissioner's proposed regulation requires statements regarding the RO decision in all ALJ decisions, regardless of the outcome, does not cure the issues that the proposed regulation raises. The likely increase in the number of appeals from ALJ denials and appellate error regarding deference, weight, and how ALJs address the ROs' decisions will defeat any potential for an increase in decision consistency between the RO and ALJ levels that the proposed regulation is intended to achieve. The creation of these issues by the proposed regulation suggests that it is not the most effective way to achieve greater consistency between the RO and ALJ decisions.

Rather than the proposed requirement that an ALJ address the RO's decision, which places a burden on the ALJ's decisional independence to justify the ALJ's treatment of the RO's decision, I respectfully submit that **an effective way to increase the consistency of decisionmaking between the RO and ALJ decision levels would be to instead require that the RO use the same legal standards for determining disability as those by which the ALJs are bound.** Rather than apply the current practice of requiring the initial agency decisionmakers to use a different and primarily medical set of standards based on a prepon-

⁵⁸ "The Appeals Council will review a case if (1) There appears to be an abuse of discretion by the administrative law judge; (2) There is an error of law; (3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence; or (4) There is a broad policy or procedural issue that may affect the general public interest." 20 C.F.R. § 404.970(a).

⁵⁹ 5 U.S.C. § 557(c).

⁶⁰ 42 U.S.C. § 405(b)(1) (emphasis added).

⁶¹ 42 U.S.C. §§ 1383(c)(1)(A).

derance of the evidence to the ROs, the ROs' decisions should be reviewed on the substantial evidence standard, the same as are the ALJs' decisions.⁶² Since the ROs will be attorneys, implementation of legal standards for their decisionmaking will be met with a success that demonstrably has not been possible with non-attorney decisionmakers, such as the failed Process Unification Training for DDS decisionmakers and Adjudication Officer initiatives in the 1990s.

C. The Administrative Placement of the Reviewing Official and the Decision Review Board within SSA

As is stated above, the RO review would replace the state agency (DDS) reconsidered determination step and the Board would replace the Appeals Council. The proposed regulations and Supplementary Information are silent regarding the administrative placement of the RO and Board within SSA. The only document issued by SSA at the time that it published the proposed regulations that addresses administrative placement is a July 2005 flowchart entitled "The Proposed SSA Disability Determination Process," which places the RO within the Office of Disability and Income Security Programs ("ODISP") but outside the OHA, which is the administrative unit that contains the ALJ hearing function.⁶³ (On February 13, 2004, senior SSA officials publicly stated that the ROs administratively are expected to be placed within the OHA but not in the OHA hearing offices, but this statement preceded the issuance of the proposed regulations and related documents.) The Board also is placed within ODISP but outside OHA in the flowchart, but it is not clear that the ROs and Board will have separate chains of authority to the Commissioner. The Appeals Council has been within OHA but administratively separate from the OHA hearing offices.

If an RO does not fully allow a disability benefits claim, the Commissioner's proposal would provide a claimant the right to appeal for a *de novo* hearing before an ALJ.⁶⁴ Accordingly, the RO's action on a benefits claim would be the last step of the Commissioner's initial decision of the disability claim, an adverse decision from which the APA and Social Security Act provide for an appeal with reasonable notice and opportunity for a hearing on the record before an ALJ.⁶⁵

Since the ROs would make the Commissioner's initial decisions of benefits claims, I respectfully submit that the Commissioner is required by the APA to administratively place the ROs outside of OHA in a separate chain of authority from both OHA and the Board. The APA requires a separation of the adjudication function of a federal administrative agency from its investigative and prosecutorial functions to preserve the decisional independence of ALJs when conducting a hearing or deciding a case. "[An ALJ] is not responsible to, or subject to the supervision or direction of, employees or agents engaged in the performance of investigative or prosecution functions for the agency."⁶⁶ "The APA separation of functions doctrine [set forth in 5 U.S.C. § 554(d)] requires only that the prosecutor and the adjudicator each be responsible to the agency head by a separate chain of authority."⁶⁷ This provision safeguards against undue agency influence and ensures that claimants receive independent adjudications of their claims. Therefore, SSA may not place its ROs in the same chain of authority to the Commissioner as the ALJs, since the ROs perform SSA's investigative and prosecutorial functions in rendering initial determinations of disability benefits claims.

I respectfully urge the Commissioner to implement (1) the administrative placement of the ROs outside of OHA, as is stated in the July 2005 flowchart, and (2) separate chains of authority to the Commissioner for the ROs, ALJ hearing function, and the Board.

Sincerely,

Robin J. Arzt

⁶² Proposed 20 C.F.R. § 405.1(b).

⁶³ "The Proposed SSA Disability Determination Process," flowchart, available at <http://www.socialsecurity.gov/disability-new-approach/> as <http://www.socialsecurity.gov/disability-new-approach/NewApproachFlowchart.pdf>.

⁶⁴ Proposed 20 C.F.R. § 405.305.

⁶⁵ 5 U.S.C. § 554(a); 42 U.S.C. §§ 405(b)(1), 1383(c)(1)(A). See also, proposed 20 C.F.R. § 405.302.

⁶⁶ 5 U.S.C. § 554(d)(2).

⁶⁷ *Columbia Research Corporation v. Schaffer*, 256 F.2d 677, 680 (2nd Cir. 1958).

Cape Coral, Florida 33904
October 5, 2005

Committee on Ways and Means
 U.S. House of Representatives
 1102 Longworth House Office Building
 Washington, D.C. 20515

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There are serious legal problems with the proposed regulations 20 CFR 404, 405, 416, and 422. Please review the following comments with regard to the most significant issues raised by the proposed regulations.

1. The regulations sandwich the Administrative Law Judge (ALJ) in between two federal reviewing bodies that the ALJ will undoubtedly be influenced by. This will significantly impair the ALJ's duty to conduct an unbiased *de novo* review for two reasons.

(a) The regulations changed the review process upon initial denial. It used to be a State agency review was conducted after initial denial. Under the new regulations, the review will be done by a Federal Expert Unit. The inclusion of a requirement in the new regulations that the ALJ must state the reasons why the ALJ disagrees specifically with the Federal Expert Unit Opinion (or guise of the State agency determination) is contrary to *de novo* review which the ALJ is obligated to perform. *De novo* review requires a fresh unbiased look at all the evidence. Federal agency opinions should not be allowed to be interjected into the ALJ administrative review process. The State agency should continue to conduct reviews of prior State agency determinations.

(b) During the *de novo* review by the ALJ, the newly proposed Decision Review Board (DRB) (see 405.405) consisting of members appointed by the Commissioner, will be prejudging ALJ decisions if a claimant has a diagnosis that has been identified by a federal computer as a potential problem for the Commissioner. This seems evident upon reading the preface to the new regulations. In the preface it is stated that there will be a list of categories of cases that will trigger red flags by the DRB and these cases will be clearly selected before the ALJ conducts the *de novo* review and I believe the majority of these cases will not reach ALJ final decisions because the DRB will take these cases up on review. A worse possible scenario is that these cases will be controlled by the Federal Expert Unit and will fall into a bottleneck where they will get backlogged and only reach the ALJ after many years of reviews and remands. This type of Federal Review will also interfere with the finality of ALJs' decisions and prevent a full and fair review by the ALJ. This has the inherent potential of creating a bias in the decisionmaking process. In the preface it is already established that certain claimants are a problem: these claimants include claimants with mental impairments, claimants who are young, and claimants who do not meet the medical listings but rather fall under the category of lacking the residual functional capacity for work. The latter group comprise a large number of my client population. The new regulations will not only prejudice large numbers claimants as not disabled but will significantly impede the ALJ's ability to conduct a full and fair review. No regulation should be adopted which compromises the *de novo* review of an ALJ.

The establishment of the Federal Review Unit (or any review unit) should have a time limit for keeping jurisdiction of a case. The existing regulations would allow the Federal Review Unit to keep a case for an endless period of time. The Federal Review Unit may also remand back to the State Agency for additional review and case development. Without a time limit for ending this review, it would be entirely possible to keep a case out of the hands of an Administrative Law Judge for an inordinate period of time. A reasonable period of review should be defined, even if it is six months to one year. After the expiration of this timeframe, a claimant should be able to assume the case has been denied and then appeal to the ALJ for a *de novo* hearing.

The Quick Decision Determination regulations should identify what disabilities or diagnoses warrant quick Decisions before the regulations are adopted.

The requirement that Attorneys submit adverse evidence is contrary to most State bar regulations and should not be adopted.

The fact that the program will start in the smallest region of the country has its downside because only a small number of cases will be going to Federal Court after an ALJ decision and it will not be possible to assess whether the Federal Court sys-

tem will be flooded with Federal Court appeals once the Appeals Council is eliminated.

The right to appeal to the Appeals Council should not be eliminated. It should be remembered that many Social Security disability claimants are not represented by Attorneys and therefore they lack the ability and skills needed to appeal to Federal Court. The Appeals Council serves a useful purpose in ensuring that these individuals receive a proper review of an unfair ALJ decision.

Changing the Reopening rules (405, 420(a)(3) and 405.605) so that only cases that show clear error on the face of the record can be reopened and reviewed is divergent from what most governmental agencies allow and it essentially sets aside the Social Security Administration from the mainstream of agencies. It has the effect of discriminating against the disabled. The majority of federal agencies allow for reopening of cases for new and material evidence. These agencies include, among others, (1) the Veterans Administration; (2) OSHA; (3) EPA; (4) Dept. of Commerce; (5) Commission on Human Rights and Opportunities; (6) the Federal Coal Miners Health and Safety program; (7) OWCP, etc. Why would the Federal Government want to segregate out the disabled as a group and prevent them from reopening their claims for new and material evidence when they allow Corporations, Veterans, and other groups to reopen for new evidence purposes? The disabled, more than any other group, need help developing their cases and new evidence should not prevent a disabled claimant from reopening.

Time limits for submitting evidence to the Administrative Law Judge are simply unreasonable. 45 days notice of a hearing with the requirement that a person submit the evidence 20 days before the hearing amounts to a maximum of 25 days to obtain evidence. Unfortunately most attorneys only get appointed to represent a client after the client gets a notice of hearing. Frequently, the client doesn't get an appointment to sit down with an attorney until days after the notice. Since the attorney must write to treating physicians and hospitals to get updated medical records and submit those records at least 20 days before the hearing, this compromises the ability of the attorney to adequately represent the client. Most hospitals use copy services for replying to requests for medical evidence. Some services take at least two months before the request is answered. Large doctors' offices do the same thing. It is therefore not generally possible to comply with these new restrictions. A case should be assigned a temporary date of hearing upon receipt of the claimant's Request for Hearing. That way a claimant can adequately plan for obtaining all the necessary medical records. If a claimant hires an attorney within three months of a temporary hearing date, a new hearing date should be assigned if the attorney requests that. At a minimum the attorney should have 90 days plus 20 days to submit all evidence to the ALJ, i.e., 110 days total.

In conclusion, I would propose that the focus of any change in the law should be primarily on assisting people to return to work after a period of disability, devising vocational programs that will work, giving tax incentives to employers to hire the disabled, and conducting careful medical cessation reviews. I would contract out the medical cessation review process.

Thank you for your kind consideration.

Very truly yours,

Carol Avard

**Statement of Shari Bratt, National Association of Disability Examiners,
Lincoln, Nebraska**

Chairman McCrery, Chairman Herger, and Members of the Subcommittees, on behalf of the National Association of Disability Examiners (NADE), I am presenting a written statement for the record on the Commissioner's proposed improvements to the Social Security Disability Determination process.

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of our members are employed by state Disability Determination Service (DDS) agencies and thus are on the "front-line" of the disability evaluation process. However, our membership also includes SSA personnel, attorneys, physicians, and claimant advocates. It is the diversity of our membership, combined with our extensive program knowledge and "hands on" experience, which enables NADE to offer a perspective on disability issues which is both unique and pragmatic.

NADE members, whether in the state DDSs, in SSA or in the private sector, are deeply concerned about the integrity and efficiency of both the Social Security and

the Supplemental Security Income (SSI) disability programs. Any change in the disability process must promote viability and stability in the program and maintain the integrity of the disability trust fund by providing good customer service while protecting the trust funds against abuse. Quality claimant service and lowered administrative costs that the American taxpayer can afford should dictate the structure of any new disability claims process. In addition, in order to rebuild public confidence in the disability program, the basic design of any new process should insure that the decisions made by all components and all decisionmakers accurately reflect a determination that a claimant is truly disabled as defined by the Social Security Act.

NADE believes that for people with disabilities, it is crucial that SSA reduce any unnecessary delays and make the process more efficient. However, any changes in the process must be practical and affordable and be implemented in a manner that allows appropriate safeguards to assure that timely claimant service is improved. NADE is not convinced that all parts of the Commissioner's proposal will achieve this and is concerned that some of the proposed changes will, in fact, increase both administrative and programmatic costs.

For the past decade, SSA has attempted to redesign the disability claims process in an effort to create a new process that will result in more timely and accurate decisions. Results of numerous tests undertaken by SSA to improve the disability process have not produced the results anticipated. The experience of past pilots has shown that ideas that may sound good in theory have proven to be inadequate to meet the demands for service and affordability when implemented on a wide scale.

There is a pervasive public perception that "everyone" is denied disability benefits at the initial and reconsideration levels, and is then allowed only when they reach the Administrative Law Judge (ALJ) level. This perception is totally inaccurate as SSA statistics show that 80 out of every 100 disability beneficiaries were allowed by the DDS. Numerous references are made to making the "right decision as early in the process as possible." NADE certainly supports that goal but wishes to point out that sometimes the right decision is a denial. The processing delays that appear to be of greatest concern to the Commissioner, and to the public, are delays that occur not at the DDS, but in association with the appeals process.

In her initial comments about a new disability approach, the Commissioner indicated the foundation for the approach was the successful implementation of an electronic folder system (eDIB). The proposed disability process improvements are built upon this new electronic folder system which is expected to reduce processing time by 25%. For eDIB to be successful, it is critically important that adequate infrastructure support and proper equipment to make the process work effectively and efficiently is in place. Until eDIB is fully implemented nationwide, it is impossible to determine critical service delivery issues that impact on daily case processing. NADE supports continued rollout of an electronic disability folder for the obvious reasons of administrative cost savings in terms of postage and folder storage, as well as time savings from mailing and retrieving paper folders. At the same time, it must be recognized that an electronic disability case process may have a negative impact on case production capacities at the DDS level.

While eDIB may be rolled out nationally in all state DDSs and territories except New York, it is not in use by all adjudicators in all components, and it remains to be seen how the system will handle the increased volume of work and number of users when it is implemented completely in all components of disability case processing. Overall, we believe that the impact of eDIB on the adjudication process will be positive. However, it is critical, that in this period of finite resources, those resources (including personnel) not be diverted from eDIB to develop the structure and procedures necessary for implementation of a new adjudicative process.

While the hardware and software for eDIB is in place in the vast majority of DDSs, the system is currently only utilized by a small minority of disability examiners. Its capacity and success remain to be seen as more users are involved. Until eDIB is fully operational, (including the predictive software to identify Quick Disability Determinations), we do not believe it is appropriate to make widespread changes in the adjudicative process. The full implementation of eDIB in itself may result in a significant reduction in processing time at all levels of adjudication without additional changes to the adjudicative process.

In addition, tools which have been demonstrated to improve efficiency, such as dual monitors, are not yet available to all adjudicators and medical consultants. Because eDIB is still a work in progress, refinements, upgrades, and improvements are frequently necessary. The impact on the system as a whole when these refinements are accomplished is unpredictable, but at the present time frequently results in slowing or shutting down the system, or parts thereof. Since DDSs process over 2½ million cases on an annual basis, any shut-down of the system equates to significant

loss of work processing capacity. *Even a shut-down of only five minutes a day equates to over 1,250 work hours lost on a daily basis due to system instability.* Currently, many DDSs experience far more than 5 minutes per day experiencing system instability problems.

In addition, some upgrades and improvements to the system require that the adjudicator relearn basic functionality which again impacts on the ability of the DDSs to process the huge number of cases they receive in a year. Upgrades to the system are essential to insure that the system operates as efficiently as possible, but it must be recognized that there is a resource impact every time a change is made.

While NADE recognizes the need for, and supports, SSA's commitment to move to an electronic disability claims process, this tool will not replace the highly skilled and trained disability adjudicator who evaluates the claim and determines an individual's eligibility for disability benefits in accordance with SSA's rules and regulations.

Although we understand that electronic case processing procedures are being developed, there is currently no process in place to handle continuing disability reviews (CDRs). The inability to process the CDR workload electronically could impact both administrative and program costs, as well as compromise program integrity.

NADE recognizes and supports the need to improve the disability decisionmaking process. We are concerned, however, that the Disability Process Improvement Initiative, with its increased reliance on medical specialists and attorneys, and its elimination of the triage approach currently being used in 20 DDSs, could increase both administrative costs and program costs. If the first level of appeal following a denial by the DDS is handled by a Reviewing Official who is an attorney, rather than by a trained disability adjudicator, such as a disability hearing officer, and if medical specialists replace programmatically trained DDS medical consultants, the disability program's administrative costs will almost certainly increase. We also suspect program costs will increase as more claims are allowed on appeal by individuals who lack the requisite medical and vocational training and background to view such claims from the perspective of SSA's definition of disability. Adjudicators evaluating Social Security and SSI disability claims must appropriately and interchangeably, during the course of adjudication, apply the "logic" of a doctor, a lawyer and a rehabilitation counselor following SSA's complex regulations and policies to arrive at a disability decision. Training in all three of these areas is critical to effectively and efficiently adjudicate these cases accurately and in a timely manner. Failure to do so carries enormous consequences for the Social Security Administration and the huge number of citizens who call upon the Agency for assistance.

In the proposal for a "quick disability determination" (QDD), appropriate claims would be identified and referred to special units in the DDS for expedited action. NADE supports the QDD being made by the DDS. However, we feel that this workload would not necessarily require that the most experienced disability adjudicators should be assigned to process these QDD cases. In our considerable practical experience with such cases, we have found that the complexity of these cases is minimal and we believe that the expertise of the more experienced disability adjudicators is best allocated to process the more complex cases. We believe that each DDS Administrator should be allowed the ability to assign their more experienced personnel to process claims as they believe best suits the needs of the DDS and the people they strive to serve.

If the decision is made to require the most experienced disability adjudicators to process QDD cases, then NADE believes that it is not necessary to require MC "sign-off" on these fairly straight-forward allowance cases. In addition, specialized units for processing QDD cases are not necessary as they would reduce production in other types of caseloads normally handled by experienced adjudicators.

It is imperative that predictive software for identifying QDD cases be manageable and accurate. It has been proposed that adjudication of 98% of these QDD cases will result in a favorable determination of disability. If that goal, as well as the goal of a 20 day processing time is not met, action will be taken to remove this caseload from the DDS. NADE does not support these punitive actions.

It is important to note that in Title II claims, those persons found disabled under the Social Security Disability program must complete a five month waiting period to receive benefits. *A disability allowance decision, no matter how quickly it is processed, will not solve the problem of having to wait five full calendar months before being able to receive any cash benefits.*

The Commissioner's proposal has recommended establishing a federal Reviewing Official (RO) as an interim step between the DDS decision and the Office of Hearings and Appeals (OHA). An interim step outlining the facts of the case and requiring resolution of the issues involved could help improve the quality and consistency of decisions between DDS and OHA components. NADE supports an interim step

because of the structure it imposes, the potential for improving consistency of decisions, reducing processing time on appeals, and correcting obvious decisional errors at the initial level. However, the Disability Process Initiative is unclear as to the method the RO would use to gather necessary medical evidence. If additional evidence is needed at that point, it would likely result in increased costs at the DDS level to provide for consultative examinations.

There is little, if any, data to support a conclusion that the interim step between the DDS decision and OHA must be handled by an attorney. In fact, a 2003 report commissioned by the Social Security Advisory Board to study this issue recommended that this position NOT be filled by an attorney. Assessment of eligibility under the Social Security Disability program requires that the adjudicator at every level possess a great deal of program, medical and legal knowledge. As currently proposed, the only qualification indicated for a Reviewing Official is that he/she be an attorney. Individuals who are hired into this new position without previous experience in the disability program will require extensive training and mentoring for a period of at least one year. It is also unclear in the proposal who would be responsible for the training and supervision of the RO.

NADE believes that a review at the interim step should be conducted by a medically and programmatically trained individual such as a disability hearing officer (DHO). The DHO has received additional training in conducting evidentiary hearings, decision writing and making findings of fact, along with detailed case analysis and program information. The DHO currently makes complex decisions using the Medical Improvement Review Standard (MIRS). There is currently a training program in place for Hearing Officers in the state DDSs. This program could easily be adapted to training experienced disability professionals to perform RO duties. Since a DHO infrastructure is already in place, national implementation of the DHO alternative could occur very quickly. Using an already established structure will prevent creation of a costly and less claimant friendly federal bureaucracy. There would be extreme cost considerations if attorneys were to fill these positions as currently is suggested.

NADE strongly supports the Commissioner's emphasis on quality as described in the proposal. There is a need for in-line and end-of-line quality review at all levels of adjudication. Accountability and feedback at each level is crucial. Nationally uniform decisions with consistent application of policy at all adjudicative levels require a consistent and inclusive quality assurance (QA) review process. A well-defined and implemented QA process provides an effective deterrent to mismanagement, fraud and abuse in the Social Security Disability program. We believe an improved quality assurance process will promote national consistency, and in turn, will build credibility into the process. NADE also supports quality reviews at all levels of adjudication, including DDSs, Reviewing Officials, and ALJs.

In regard to the Federal Expert Unit (FEU), NADE believes the FEU can provide DDSs with additional access to medical and vocational expertise. Qualification standards for inclusion in the FEU should not exclude the knowledgeable state agency medical consultant. DDS medical consultants are trained in program requirements, and the majority of the cases they review include multiple impairments. Having specialists review each impairment individually is a time consuming, costly proposal. Specialty consultants with limited scope and experience cannot fully assess the combined effects of multiple impairments on an applicant's functioning. DDS medical consultants are not only medical specialists—physicians, psychologists or speech/language pathologists—they are also SSA program specialists.

Although members of the FEU will surely be highly qualified to treat patients in their respective fields of specialty, they will also require extensive training in the area of determining disability. Evaluating eligibility for Social Security disability is a far different area of expertise than treating patients. There is a very real difference between clinical and regulatory medicine, and it takes at least a year to become proficient in Social Security disability rules and regulations. Again, the responsibility for training, mentoring, and supervising these experts is not established in the Commissioner's proposal.

Salaries for both the RO and members of the FEU will be much higher than those of Disability Examiners and Hearing Officers at the state DDS. In addition, there will be a lengthy period of time while the individuals assigned to these new positions will not be capable of independent assessment of disability eligibility. While we support the concept of the FEU being used to supplement the expertise of the Medical Consultant at the DDS, we feel that most cases at the initial level should continue to be reviewed and evaluated by state agency medical consultants.

NADE supports the proposal to retain a *de novo* hearing before the ALJ, with the requirement that the ALJs provide in their decisions an explanation as to why they agree or disagree with the rationale of the RO's decision. NADE also supports the

concept of timely submission of evidence as outlined in the proposal. Submission of evidence no later than 20 days appears reasonable and may increase the ability to process hearing requests in a timelier manner.

NADE also supports the establishment of a Decision Review Board consisting of both ALJs and Administrative Appeals Judges serving staggering terms to conduct disability review functions. NADE agrees that a gradual roll-out process would be most effective. The NPRM proposes to gradually eliminate the Appeals Council only in those regions where the changes in the NPRM have been implemented and NADE supports this concept.

In summary, NADE's key recommendations are to implement only strategies which balance the dual obligations of stewardship and service. These are:

- Do not divert resources from eDIB until the system is fully operational in all DDS locations.
- Eliminate or reduce the five-month waiting period for Social Security beneficiaries.
- Extend presumptive disability provisions to Social Security disability claimants.
- Fully integrate the Single Decision Maker into any new disability process.
- Utilize the current infrastructure of DDS Disability Hearing Officers as an interim appeals step.
- Require adequate training in the medical and vocational program requirements for all decisionmakers in all components.
- Include both in-line and end-of-line reviews at all levels of the process.
- Recognize that technology is only a tool. It does not replace the highly skilled trained disability examiner.

NADE appreciates this opportunity to present our views on the Commissioner's Disability Improvement plan and we look forward to working with the Social Security Administration and the Congress as the Commissioner continues to refine the disability process.

Statement of David Bryant, La Grange, Illinois

I Looked over the 79 pp of Federal Register (70 #143, 43589-43624, July 27,2005) proposed rules over an August weekend at our summer place in Michigan. In spite of some problems, this could work if the ALJs still use some common sense and discretion. The real problem being addressed is a reduction in time it takes to get to a final result on a consistent and fair basis. The proposed process will not accomplish this no matter how hard the system tries to implement these changes, some of which are good.

Four general comments and ten specific comments on the proposals follow:

In general, speeding the process would be good. One example from a private sector impact. Many employers provide employees with Long and Short Term Disability insurance (STD & LTD). If an employee on LTD for 2 years or more does not provide the LTD insurance company with evidence of a successful Social Security Disability claim (i.e. Award), some LTD benefits may be stopped.

In general, advocates have long tried to persuade SSA to have all decisionmakers "on the same page" (i.e. the State adjudicator and the ALJ and the Courts follow the same rules/laws). The proposed changes fail in several respects. Claimant attorneys never fail to hear/read about SSA being a "national program" yet SSA's own statistics show that people with the same disabilities have a better chance of approval if they live in one state compared to another. Is the heart in Wisconsin different than the heart in Washington? The back in New Hampshire weaker than the back in Texas?

In general, the issues surrounding evidentiary matters will result in significant court actions involving rights of subpoena, right to cross examine witnesses, abuse of discretion, bias, failure of notice, ethical obligations of attorneys and non-attorneys to represent clients, and questioning of expertise. In addition, the Courts will be flooded with new cases similar to the early 80s.

In general, the system will become ripe for internal scandal and gross violations of ancillary laws, both state & federal, such as privacy. The privatization by contract to outside file organizers in Milwaukee is but one example. Use of electronic file folders (E-DiB) will increase the ease of identity theft unless extreme caution and security is incorporated in the process. Will LTD carriers require insureds to hand over the CD as a condition of continued payments? Will outside contractors "lose" records like Wells Fargo, LEXIS, Citibank, etc.? If so, what is the penalty?

In particular, I have some questions about the stated intentions in background and the actual proposed regulations. I will present them as found with reference to the page.

1. (p. 4) I have asked for a copy of the Service Delivery Budget Assessment Team research reports on the time to make a decision in 1,153 days on average. In current practices, some DOs are entering the fact that a Request for Hearing was filed and sent to the OHA yet putting the file in a box to wait with all the others until two or three boxes are ready to ship. The computer record shows the file at OHA but in fact, not. This increases the “time” that OHA has the file for workup when in fact it does not. Also, Chicago HOMs have taken a position that the attorney cannot review the “raw” file (i.e. paper) until the file is “worked up.” In my own practice, I try to look at the file ASAP in order to (1) write a short note to the Attorney Advisor asking for an On the Record decision since a very strong case (2) make a list of the medical records that are missing, get, and submit in order to strengthen the claim (3) decide to invest \$350.00 in a psych consult since the client is a nut case that refuses treatment. In other words, try to move the case forward. Under current practices and conditions anticipated in reform, this may be difficult. The existing systems and proposed reforms have built in delays based on resource allocation.

2. (pp. 4–5) EDCS is a good idea, as is the teleconference hearing. The State of Illinois adjudicators I talk to still seem to accept paper and deal with that as a time saver since many of the ADL Q and Pain Q that I receive as copies (originals to clients) have a self mailer that goes to Kentucky for scanning. Once the Pain Questionnaire is answered for the second time and placed in the electronic file folder, will the first one be destroyed? erased? Should I advise clients to keep copies of everything they submit? The DOs all want original birth certificates with seals, marriage, divorce, WC Settlements in the original. Copies are made and originals are returned most of the time.

Will there still be two file folders/sections for SSI & DIB claims? Will TSC gatekeepers still insist on having an SSI claim file made and dismissed proforma in spite of the fact you have advised them that the client is married to a working spouse and getting \$800 every week in WC? SSA's voiced “concern” for applicants is a bogus cover for increased statistics on case dispositions and should be stopped.

3. (p. 5) CPMS is being used by OHA. I am trying to find out if the coding ID for the client (like a UPL scanning code for checkout at the supermarket) is the same at the State level and the OHA level? Or must the file be re-scanned and recoded?

4. (p. 6, 10–11) Quick Disability Determination (QDD) for the clearly disabled is a good idea but is not new. This has been around for years. What is new is the “predictive model screening software tool.” I have asked for a copy of that “software” in order to format really sick client's applications to meet this criteria. Since the science and practice of medicine changes so rapidly, the basis for this tool should be interesting. Who made it? A similar “tool” was created in the 80s for CDRs at the University of Michigan to answer the question “which type of claimant is likely to recover from a particular illness (i.e. heart attack under 40).” How this will happen in 20 days as proposed is a question that needs review. 30 is probably more realistic if a medical expert is required to sign off.

5. (pp. 11–13) The Federal Expert Unit is also a great idea. If I was younger, I would put together a nationwide network of MEs & VEs that already network on PI and WC cases anyway, and get them “qualified” under standards yet to be developed by the National Institute of Medicine; and then bid on the job. I will ask the NIM for information about this set of standards and who is the contact person. Since SSA “plans to undertake a study” about RFC assessments, I will assume the *DOT*, *SCODDOT* and “O-Net” will be back in play. One small problem, how will a VE from California identify jobs in the Chicago SMA? Another problem, if the standards for medical consults (both in-house and outside) are too high and the pay is poor, the clients will get the dregs, part time residents, or none at all. I expect that many doctors who have “retired” and testify at ALJ hearings will find other work as well. The idea may stumble on the reality of lack of resources.

6. (pp. 13–14) Federal Reviewing Official by an attorney in Federal pay is nothing more than the Feds taking over Reconsideration and dressing it up. These “highly qualified individuals” who will be “thoroughly trained” reflect the ambitions of the NTEU members and wannabe ALJs taking over the QR function done at regionals.

Any FRO decision must explain why a denial occurred yet no where in the proposals is there a timeframe for such decision (See: *Deloney* class action consent decree). I failed to note any de novo protection of the ALJ decision if the ALJ is required to explicitly rebut the FRO decision.

7. (pp. 14–18) ALJ Decisions I can live with so long as Closing the Record is not used with a vengeance. Other people can deal with the medical record timeframe issues. In short, unrealistic.

8. (pp. 18–20) Decision Review Board replaces the Appeals Council. So what. After the ALJ denial and absent receipt of a Notice from DRB, I would file ASAP in Federal Court if there is a good reason. There is no prohibition of filing sooner than the 60 days and move it to the OGC. This move will inundate the Federal Courts and they will lobby Congress to change the law to deny jurisdiction except in Constitutional cases. (Posner Commission Report). Given the current political climate, it might fly. If you do get a DRB Notice within the 90 days, make sure you send any arguments/evidence by certified mail to raise the issue of “Closed Record” for federal court. Just because the SSA says “it is so” doesn’t mean much to a Federal Judge.

9. (pp. 21–22) Implementation. This is an administrative nightmare. To roll out a significant change in process on a region by region basis in order to gain experience and time to fine tune the process makes administrative sense. If the APA truly means “no person shall be adversely affected by any rule unless first published in the Federal Register” and if this is truly a national program, I predict that people asking for disability benefits under the old system may fare better than those under this “new” system. I dread the call from a client moving from the Chicago area to a Region using the “new” system. Should I advise a client to move out of a “new” Region to an “old” Region in order to submit material medicals to the Appeals Council? Will the visiting ALJ from San Bernardino impose “his” system used in California? or the system used in Illinois? SNAFU time.

10. Money. State of Illinois will get reimbursed only for “qualified” expert costs once Illinois becomes a State Agency within the new system. I have suggested in the past that the State of Illinois get out of the business of making these decisions and turn it over to the Feds. Why not? Jobs & politics in my opinion. The Feds are terrified that any State might do this since the costs would double due to Fed wage scales and benefits compared to State payrolls.

**Statement of Linda Fullerton, Social Security Disability Coalition,
Rochester, New York**

Second Wave Of Disaster Ahead

While the majority of Americans were shocked at the reaction of the Federal Government in the aftermath of hurricane Katrina, I was not surprised at all. I have been personally devastated by the Federal Government, and have seen the horrifying results of their incompetence on a grand scale for the past few years. My personal story can be found here—Please check out my website at:

<http://www.frontiernet.net/~lindafl/bump.html>

Nowhere is this more evident, yet rarely mentioned, than in the way the Social Security Administration treats the disabled population of this country. Americans saw in a major way since hurricane Katrina struck, how the poor and disabled were left to die in the streets when they needed help the most. The SSA has been systematically destroying disabled Americans for decades, and Congress as a whole has failed miserably to do anything about it.

While Commissioner Barnhart’s proposed revamp of the Social Security Disability program was a great gesture during the week of the ADA anniversary, it does not go far enough, fast enough for those who desperately need to access disability benefits and whose very lives depend on them. Even many Social Security Administration employees themselves do not agree with the Commissioner’s current proposals, as they too see what a detriment they are to the lives of disability claimants. SSA employees, as well as many disability organizations such as mine, have been kept out of these hearing proceedings, yet we are the ones most affected by the outcome. This needs to change immediately. Our organization is one who has provided constant feedback throughout this whole process to the commissioner’s staff. The majority of our members are those who are actually receiving, or are going through the horrendous claims process itself, trying to get Social Security Disability benefits, so we know first hand where the problems are.

The SSDI/SSI program is currently set up to discourage and destroy as many claimants as possible so benefits do not have to be paid out to them. Over 68% of claims are denied at the initial filing for benefits. To date the SSA has determined that it can take up to 1,153 days (3¼ years) or longer for a claim to be processed if it is denied at every level which often occurs. That waiting time is about to increase as the SSA Commissioner has made proposals which will force thousands

more into the already backlogged Federal Court system. The disabled are also made to wait 2 years to get vital Medicare benefits while healthy citizens can access them immediately upon reaching retirement age. The poverty that often results from waiting for these Federal claims to be approved and Medicare benefits, forces thousands into already over-burdened state Medicaid and Social Service programs who would never have needed them, had they had their claims approved in a timely manner. Then once their SSDI/SSI benefits are finally received, many states require the disabled to pay back any state benefits that they received, yet healthy Americans are not required to do so. This creates a cycle of endless poverty, where they now have to now rely on both state and Federal programs to survive, and from which they can never recover, since they can no longer work. They are then viewed, as the world just witnessed first hand, as “disposable” citizens. Yet, the thousands of our horror stories of homelessness, bankruptcy, destruction and death at the hands of the SSA, do not make the news.

My years of pleas to the President and Congress to get these people help have been, with a few exceptions, virtually ignored. I shudder to think of how many more lives will be further devastated or lost, when the mentally and physically disabled victims of Katrina, encounter their next experience with the Federal Government as they apply for their SSDI/SSI benefits. We ask that Congress act now to fix the SSDI/SSI system properly, without further harm to this extremely fragile population. We as claimants who have actually gone through the SSDI system, want to be part of a group who actually continues to participate in the Social Security Disability New Approach program, and all hearings relating to all aspects of Social Security reform. We want to have major input and influence on the decisionmaking process before any final decisions/changes/laws are instituted by the SSA Commissioner or Members of Congress. This is absolutely necessary, since nobody knows better about the flaws in the system and possible solutions to those problems, than those who are forced to go through it and deal with the consequences when it does not function properly. We are your mothers, fathers, sisters, brothers, friends, and many of us are veterans who have served this country. Wake up America—at any point in time, this could be you or someone you love!

Social Security Disability New Approach Program Proposals Meager At Best—Major Reform Still Needed

First of all, I must say that the women I spoke with on the Commissioner's staff—Sonia De La Vara and Mary Chatel were very responsive and helpful to my organization as we tried to submit feedback to the Commissioner during the New Approach process. They are to be highly commended for their hard work and in my estimation are shining examples of how all SS employees should be. We are also very pleased to see the establishment of a QDD process (quick disability determination) for the obviously disabled which is long overdue, especially for those who suffer from terminal illness, who currently in many cases, die before they get approved for benefits. That being said, I was shocked to see that the Commissioner herself, has vastly ignored the feedback that was submitted from our group as she moves forward with her proposed changes to the SSDI program.

High priority should be given to increase SSA staffing levels, and provide better employee training, in all phases of the disability process, especially in the initial contact phases with field offices and DSS offices across the board. Instead we are hearing that staff levels are being reduced as backlogs in the system are increasing! More effort should be made to thoroughly review a disability claim at the start, giving more proper weight to claimants treating physicians, which is part of Social Security law, but is often not followed when making decisions throughout the claims process. There should be more effort on the part of SS to assist applicants throughout the entire disability claim process, including ongoing contact with claims examiners, assistance with developing the medical file to ensure all pertinent medical evidence is in file, and that the claimant is contacted if anything is lacking, before making a decision on their claim.

The establishment of a Federal Reviewing Official (RO) level of review, that would issue decisions based on review of record, is also a welcome change, as we feel that currently not enough time is spent looking at the medical records supplied by applicants and this results in premature denials and more ALJ hearings.

To date the Social Security Administration has determined that it can take up to 1,153 days (3¼ years) for a claim to be processed if it is denied at every level which often occurs. The Commissioner has stated that she hopes to reduce that wait time by 25% or down to 2¼ years. While any reduction in wait time is good, this is still appalling, and shows that she is totally out of touch with the realities that disability applicants face. I am sure that if she, or anyone else in the Federal Government had to endure living under the conditions that a 2¼ year wait time for

benefits brings, in addition to the hardships caused by one's disabling conditions, they could not fix the system fast enough.

We are not in favor of any changes that would result in more hearings, lesser back payments or a greater reliance on attorneys for claimants to receive benefits. The Commissioner has proposed that a record would be closed after an ALJ issues a decision and new/material evidence would only be allowed to be submitted under certain limited circumstances. This is totally unacceptable, given that a great number of ALJ decisions are currently appealed due to rampant bias against claimants, fraudulent behavior and poor performance by the ALJ's currently serving.

While the commissioner states that the quality review process will be improved, it often adds at least an additional 4 week waiting period to claims processing, and often targets approvals rather than denials and in the future should focus more on why cases are denied rather than approved. To better streamline her current Review of Decisions proposals and to further speed up the claims process—the DRB (Decision Review Board) and Federal Quality Review processes should be combined.

We also feel that the CDR process (Continuing Disability Review) process needs to be looked at as well. Claimants with obvious incurable chronic conditions should not have to endure the stress of these reviews, (a further detriment to their health) as the nature of these diseases cause a patient to gradually deteriorate over time—not improve. Many who under SS guidelines, still qualify for benefits are being forced into hearing situations and overpayment issues due to mistakes or outright fraud on the part of the SSA, again to purposely keep people from these vital benefits. It is also a major waste of time and SS resources that could be used elsewhere in the system. It is said that these reviews are done to prevent fraud. Trust me, nobody in their right mind would want to live under the conditions that the majority of SSD claimants and recipients are forced to endure. The majority would much rather have their health back and the jobs they once had before their lives were changed by illness or accidents.

Any corporation in this country who ran their business this poorly, would be out of business in it's first year! As evidenced by the Commissioner's current press release, most of our concerns were largely ignored or the solutions were severely lacking. SSA Customer service is extremely poor and in major need of improvement across the board. Here is just a small sampling of the constant complaints we receive about the Social Security Disability system and its employees:

Severe understaffing of SSD workers at all levels of the program.

Extraordinary wait times between the different phases of the disability claims process.

Employees being rude/insensitive to claimants.

Employees outright refusing to provide information to claimants or do not have the knowledge to do so.

Employees not returning calls.

Employees greatly lacking in knowledge of and in some cases purposely violating Social Security and Federal Regulations (including Freedom of Information Act and SSD Pre-Hearing review process).

Claimants getting conflicting/erroneous information depending on whom they happen to talk to at Social Security—causing confusion for claimants and in some cases major problems including improper payments.

Complaints of lack of attention or totally ignoring—medical records provided and claimants concerns by Field Officers, IME doctors and ALJ's.

Fraud on the part of DDS/OHA offices, ALJ's, IME's—purposely manipulating/ignoring information provided to deny claims.

Complaints of lost files and files being purposely thrown in the trash.

Complaints of having other claimants information improperly filed/mixed in where it doesn't belong causing breach of security.

Complaints of backlogs at payment processing centers for initial payments once claim is approved.

Federal Quality Review process adding even more wait time to claims processing, increasing backlogs, no ability to follow up on claim in this phase.

Poor/little coordination of information between the different departments and phases of the disability process.

These complaints refer to all phases of the SSD process including local office, Disability Determinations, Office of Hearings and Appeals, Payment Processing Centers and the Social Security main office in MD (800 number).

NOTE: These Federal regulations are being violated on a daily basis all over the country:

**CODE OF FEDERAL REGULATIONS PART 404—
FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950—)**

404.1642 Processing time standards

http://www.ssa.gov/OP_Home/cfr20/404/404-1642.htm

(a) General. Title II processing time refers to the average number of days, including Saturdays, Sundays, and holidays, it takes a State agency to process an initial disability claim from the day the case folder is received in the State agency until the day it is released to us by the State agency. Title XVI processing time refers to the average number of days, including Saturdays, Sundays, and holidays, from the day of receipt of the initial disability claim in the State agency until systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) Target levels. The processing time target levels are:

(1) 37 days for title II initial claims.

(2) 43 days for title XVI initial claims.

(c) Threshold levels. The processing time threshold levels are:

(1) 49.5 days for title II initial claims.

(2) 57.9 days for title XVI initial claims.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991].

404.1643 Performance accuracy standard

http://www.ssa.gov/OP_Home/cfr20/404/404-1643.htm

(a) General. Performance accuracy refers to the percentage of cases that do not have to be returned to State agencies for further development or correction of decisions based on evidence in the files and as such represents the reliability of State agency adjudication. The definition of performance accuracy includes the measurement of factors that have a potential for affecting a decision, as well as the correctness of the decision. For example, if a particular item of medical evidence should have been in the file but was not included, even though its inclusion does not change the result in the case, that is a performance error. Performance accuracy, therefore, is a higher standard than decisional accuracy. As a result, the percentage of correct decisions is significantly higher than what is reflected in the error rate established by SSA's quality assurance system.

(b) Target level. The State agency initial performance accuracy target level for combined title II and title XVI cases is 97 percent with a corresponding decision accuracy rate of 99 percent.

(c) Intermediate Goals. These goals will be established annually by SSA's regional commissioner after negotiation with the State and should be used as stepping stones to progress towards our targeted level of performance.

(d) Threshold levels. The State agency initial performance accuracy threshold level for combined title II and title XVI cases is 90.6 percent.

The following list of reforms and concerns was compiled and submitted to the Commissioner's staff early on, based on the actual experiences of our members and those who have signed the Social Security Disability Reform petition:

We want disability benefits determinations to be based solely on the physical or mental disability of the applicant. Neither age, education or any other factors should ever be considered when evaluating whether or not a person is disabled. If a person cannot work due to their medical conditions—they CAN'T work no matter what their age, or how many degrees they have. This is blatant discrimination, and yet this is a standard practice when deciding Social Security Disability determinations and should be considered a violation of our Constitution. This practice should be addressed and eliminated immediately.

All SSD case decisions must be determined within three months of original filing date. When it is impossible to do so a maximum of six months will be allowed for appeals, hearings etc.—NO EXCEPTIONS. Failure to do so on the part of SSD will constitute a fine of \$500 per week for every week over the six month period—payable to claimant in addition to their awarded benefit payments and due immediately along with their retro pay upon approval of their claim. SSD will also be held financially responsible for people who lose property, automobiles, IRA's, pension funds, who incur a compromised credit rating or lose their health insurance as a result of any delay in processing of their claim, which may occur during or after (if there is failure to fully process claim within six months) the initial six month allotted processing period.

Waiting period for initial payment of benefits should be reduced to two weeks after first date of filing instead of the current five month waiting period. The with-

holding of five months of benefits greatly adds to the financial burden of a claimant, and compromises their financial status to a point, that most can never recover from due to their inability to work. There is no good reason given for this huge withholding of benefits, and even the states do better than this, when processing claims for unemployment insurance—withholding amounts are often only a few weeks at most. Also prime rate bank interest should be paid on all retro payments from first date of filing, due to claimants, as they are losing this as well while waiting for their benefits to be approved.

A majority of SSD claimants are forced to file for welfare, food stamps and Medicaid, another horrendous process, after they have lost everything due to the inadequacies in the Social Security Disability offices and huge claims processing backlog. If a healthy person files for Social Service programs and then gets a job, they do not have to reimburse the state once they find a job, for the funds they were given while looking for work—why are disabled people being discriminated against? Claimants who file for Social Service programs while waiting to get SSD benefits, in many states have to pay back the state out of their meager SSD/SSI benefits once approved, which in most cases keeps them below the poverty level and forces them to continue to use state funded services. They are almost never able to better themselves and now have to rely on two funded programs instead of just one. This practice should be eliminated. In all states there should be immediate approval for social services (food stamps, cash assistance, medical assistance, etc.) benefits for SSD claimants that does not have to be paid back out of their SSD benefits once approved.

Immediate eligibility for Medicare/Medicaid upon disability approval with NO waiting period instead of the current 2 years. The current two year waiting period causes even further harm to an applicant's already compromised health and even greater financial burden on a population who can least afford it, since they cannot work. This also forces many to have to file for Medicaid/Social Service programs who otherwise may not have needed these services if Medicare was provided immediately upon approval of disability benefits.

If we provide sufficient medical documents when we originally file for benefits why should we ever be denied at the initial stage, have to hire lawyers, wait years for hearings, go before administrative law judges and be treated like criminals on trial?

Too much weight at the initial time of filing, is put on the independent medical examiner's and SS caseworker's opinion of a claim. The independent medical examiner only sees you for a few minutes and has no idea how a patient's medical problems affect their lives after only a brief visit with them. The caseworker at the DDS office never sees a claimant. The decisions should be based with much more weight on the claimant's own treating physicians opinions and medical records. In cases where SSD required medical exams are necessary, they should only be performed by board certified independent doctors who are specialists in the disabling condition that a claimant has (example—Rheumatologists for autoimmune disorders, Psychologists and Psychiatrists for mental disorders).

SSD required medical exams should only be performed by board certified independent doctors who are specialists in the disease that claimant has (example—Rheumatologists for autoimmune disorders, Psychologists and Psychiatrists for mental disorders). Independent medical exams requested by Social Security must only be required to be performed by doctors who are located within a 15 mile radius of a claimants residence. If that is not possible—Social Security must provide for transportation or travel expenses incurred for this travel by the claimant.

All Americans should be entitled to easy access (unless it could be proven that it is detrimental to their health) and be given FREE copies of their medical records including doctor's notes at all times. This is crucial information for all citizens to have to ensure that they are receiving proper healthcare and a major factor when a person applies for Social Security Disability.

ALL doctors should be required by law, before they receive their medical license, and made a part of their continuing education program to keep their license, to attend seminars provided free of charge by the SSA, in proper procedures for writing medical reports and filling out forms for Social Security Disability and SSD claimants.

More Federal funding is necessary to create a universal network between Social Security, SSD/SSI and all outlets that handle these cases so that claimant's info is easily available to caseworkers handling claims no matter what level/stage they are at in the system. All SSA forms and reports should be made available online for claimants, medical professionals, SSD caseworkers and attorneys, and be uniform throughout the system. One universal form should be used by claimants, doctors, attorneys and SSD caseworkers, which will save time, create ease in tracking sta-

tus, updating info and reduce duplication of paperwork. Forms should be revised to be more comprehensive for evaluating a claimant's disability and better coordinated with the SS Doctor's Bluebook Listing of Impairments.

Institute a lost records fine—if Social Security loses a claimant's records or files an immediate \$1,000 fine must be paid to claimant.

Review of records by claimant should be available at any time during all stages of the SSD determination process. Before a denial is issued at any stage, the applicant should be contacted as to ALL the sources being used to make the judgment. It must be accompanied by a detailed report as to why a denial might be imminent, who made the determination and a phone number or address where they could be contacted. In case info is missing or they were given inaccurate information the applicant can provide the corrected or missing information before a determination is made. This would eliminate many cases from having to advance to the hearing and appeals phase.

The SSA "Bluebook" listing of diseases that qualify a person for disability should be updated more frequently to include newly discovered crippling diseases such as the many autoimmune disorders that are ravaging our citizens. SSD's current 3 year earnings window calculation method fails to recognize slowly progressive conditions which force people to gradually work/earn less for periods longer than 3 years, thus those with such conditions never receive their 'healthy' earnings peak rate.

The claims process should be set up so there is no need whatsoever for claimant paid legal representation when filing for benefits and very little need for cases to advance to the hearing and appeal stage since that is where the major backlog and wait time exists. The need of lawyers/regs to navigate the system and file claims, and the high SSD cap on a lawyer's retro commission is also a disincentive to expeditious claim processing, since purposely delaying the claims process will cause the cap to max out—more money to the lawyer/reg for dragging their feet adding another cost burden to claimants. Instead, SS should provide claimants with a listing in every state, of FREE Social Security Disability advocates/regs when a claim is originally filed in case their services may be needed.

Audio and/or videotaping of Social Security Disability ALJ hearings and during IME exams allowed at all times to avoid improper conduct by judges and doctors. A copy of court transcript should automatically be provided to claimant or their representative within one month of hearing date FREE of charge.

Strict code of conduct for Administrative Law Judges in determining cases and in the courtroom. Fines to be imposed for inappropriate conduct towards claimants.

We have heard that there is a proposal to give SSD recipients a limited amount of time to collect their benefits. We are very concerned with the changes that could take place. Since every patient is different and their disabilities are as well, this type of "cookie cutter" approach is out of the question. We especially feel that people with psychological injuries or illness would be a target for this type of action. Some medical plans pay 80% for treatment of biological mental health conditions, but currently Medicare only pays 50% for an appointment with a psychiatrist. This often prohibits patients from getting proper treatment and comply with rules for continual care on disability. The current disability review process in itself is very detrimental to a patient's health. Many people suffer from chronic conditions that have NO cures and over time these diseases grow progressively worse with no hope of recovery or returning to the workforce. The threat of possible benefits cut off, and stress of a review by Social Security again is very detrimental to a recipient's health. This factor needs to be taken into consideration when reforming the CDR process. In those cases total elimination of CDR's should be considered or a longer period of time between reviews such as 10–15 years rather than every 3–7 years, as is currently the case. This would save the SSA a great deal of time, money and paperwork which could then be used to get new claimants through the system faster.

Until the majority of these reforms are implemented and these issues are addressed, disabled Americans will continue to suffer at the hands of a Federal Government program that was originally put in place to help, not harm them. Currently many SSD applicants are losing all their financial resources and even their lives while waiting to get their benefits—these injustices and systematic destruction of disabled Americans has to be stopped immediately. We are watching, we are waiting, we are disabled and we vote!

Social Security Disability Reform Petition—read the horror stories from all over the nation:

<http://www.petitiononline.com/SSDC/petition.html>

Social Security Disability Coalition—offering FREE knowledge and support with a focus on SSD reform:

<http://groups.msn.com/SocialSecurityDisabilityCoalition>

Please check out my website at:

<http://www.frontiernet.net/~lindafl/bump.html>

"I am disabled and my vote counts too!"

Statement of Keith Holden, M.D., Orlando, Florida

I am a licensed physician, board certified in Internal Medicine, and was a medical consultant for Florida's Department of Disability Determination Services (DDS) for seven years. I also worked for Georgia's department of Disability Adjudication Services for fifteen months.

I'm disturbed by the fact that Social Security's proposed rule for the "Administrative Review Process for Adjudicating Initial Disability Claims" does not outline an enhanced training program for its decisionmakers. Ask any successful major corporation, and they'll tell you that having an effective training program for its workers is as important as having money to perform its daily functions. I argue that Social Security's failings at prior attempts to redesign the adjudicative process are, in part, based on the lack of an effective training program; and that this ongoing oversight will play a role in the possible failure of this current attempt.

The Commissioner's new plan proposes that State agencies will better document and explain the basis for determinations so as to result in more accurate initial determinations. The Commissioner told the "National Association of Disability Examiners" that state DDS examiners would be responsible for development and review of the medical and vocational input, writing the RFC, and preparing the denial following a legal decisional logic thought process. The examiner will be required to fully document and explain the basis for their determination.

This reflects what the Commissioner has said about administrative law judges expressing concern about the quality of adjudicated records they receive. Clearly, many claimants' cases are not fully developed and documented by disability examiners. This is due to multiple reasons. I have discussed this situation with examiners in Florida and Georgia after I found that a significant number of cases that had not been properly developed were routinely routed to medical consultants. The main reasons stated for not doing so were that caseloads were excessive and unmanageable, job expectations were unrealistic, and training was woefully inadequate.

Case management by disability examiners, from the medical perspective, is sometimes inadequate, partly due to their lack of understanding of the clinical and functional aspects of claims. Inconsistency in training, and the lack of sufficient ongoing medical training once examiners reach their assigned units, produces a core group of examiners who do not understand the clinical aspects of cases. This results in examiners who can't develop medical issues with any significant degree of consistency or efficiency. This is part of the reason why some examiners admittedly don't attempt to read or develop the medical evidence in some complex cases. They route those cases to a medical consultant to unravel the issues, and subsequently complete the proper form, or return the case with recommendations for further development. This problem is only magnified in the significant number of DDS offices that have a high turnover of examiners, as those offices are relying on a large group of novices with little training and experience. It is well-known that examiners can't perform their jobs efficiently until they have had one to two years of training.

Examiners are expected to act as medical detectives and determiners of functional ability relating to physical and mental impairments. They are expected to have this capability despite a training curriculum which is essentially a crash course of very limited medical terminology and pathophysiology. The training they receive is very basic with an emphasis on anatomy and medical terms. This training emphasizes terms rather than clinical concepts, and is given in a relatively short timeframe without sufficient ongoing medical education. This limits their ability to think critically in applying that knowledge to complex medical issues found in many cases.

Some States have been designated "prototype" States, in which examiners are allowed to adjudicate claims without input from medical consultants. In one review, it was found that approximately 70% of examiners sought input from medical consultants anyway. That is a strong indication that those examiners, who supposedly had been trained to adjudicate claims without medical consultant input, did not feel qualified to do so. In fact, I have spoken to examiners in Florida, who were not happy with the fact that they had been instructed by supervisors to do "Single Decision Maker (SDM)" claims in an effort to reduce case loads and decrease cost. Com-

mon statements made by them included, “I am not a doctor” and “I don’t have the training to do this.”

The concept behind SDM is that examiners in these prototype States would decide which cases were easiest to adjudicate, and make SDM decisions on those without input from medical consultants. As with most good intentions undermined by poor planning, this experiment morphed into a short-cut for examiners to expedite clearance of cases without proper oversight by medical experts. When many DDSs in these prototype States formed units to do “Quick Decision” cases even before the Commissioner touted this concept, that left examiners on regular units with the more difficult cases to adjudicate. With SDM being praised by the SSA leaders as a way to save millions of dollars by not having to pay medical consultants for their input, these States felt obliged to press examiners to perform SDM claims even though many no longer had access to the easiest cases. The result is that many difficult claims that should have had expert medical input before being adjudicated were decided by examiners without proper insight or training.

In relation to the purely medical aspects of disability claims, this practice is comparable to letting a medical assistant in a doctor’s office complete the Residual Functional Capacity (RFC) form or Psychiatric Review Technique Form (PRTF). The irony is that while medical assistants and examiners have similar non-clinical medical training, medical assistants, unlike most disability examiners, have clinical medical experience. Theoretically, this clinical experience would let medical assistants do a better job of completing those residual function forms. This fact is clearly a disservice to disability applicants, as well as improperly trained disability examiners.

The majority of examiners I spoke with in Georgia and Florida made it clear to me that they do not feel they have been properly trained to complete an RFC or PRTF, much less write a detailed rationale for their decision. They admitted they do not have a clear grasp on how the physiologic issues relating to medical impairments impact functional abilities. This type of application of knowledge requires critical thinking. Critical thinking involves solving problems, formulating inferences, calculating likelihoods, and making decisions when the thinker is using skills that are effective for a particular context and type of thinking task. In the role of the examiner, it requires judging ambiguity and judging whether statements made by authorities are acceptable in the context of complex medical issues. It also requires examiners to have the ability to respond to material by distinguishing between facts and personal opinions, judgments and inferences, and the objective and subjective.

Compound this issue with the fact that some States don’t require examiners to have more than a high school education, and you are looking at a set-up for failure. This issue of State job requirements for disability examiners, which plays a role in the inconsistency of decisionmaking between different States, is only one example of the many problems associated with the current federal-state relationship in the Social Security disability program. See the GAO’s January 2004 publication, “Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services” for more information on this topic.

The current DDS training program, of which was a part, in no way adequately prepares disability examiners for their job duties. Issues of inadequate training have been voiced by numerous organizations providing oversight for the SSA. The Social Security Advisory Board’s (SSAB) August 1998 report “How SSA’s Disability Programs Can Be Improved,” stated “The most important step SSA can take to improve consistency and fairness in the disability determination process is to develop and implement an ongoing joint training program for all of the 15,000 disability adjudicators, including employees of State disability determination agencies (DDSs), Administrative Law Judges (ALJs) and others in the Office of Hearing and Appeals (OHA), and the quality assessment staff who judge the accuracy of decisions made by others in the decisionmaking process.” It went on to say “We urge the Commissioner to make a strong ongoing training program a centerpiece of the agency’s effort to improve the accuracy, consistency, and fairness of the disability determination process, and to see that the necessary resources are provided to carry it out.”

The General Accountability Office’s (GAO) March 1999 report “SSA Disability Redesign Actions Needed to Enhance Future Progress,” stated “Training has not been delivered consistently or simultaneously to all groups of decisionmakers.” The SSAB’s September 1999 report “How the Social Security Administration Can Improve Its Service to the Public,” stated “SSA may also be underestimating staff training needs.”

The GAO’s January 2004 publication, “Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services,” noted that the Social Security Advisory Board has cited training as one of the issues associated with inconsistencies in disability decisions. It went on to say that gaps

in key knowledge and skill areas were part of the key challenges DDSs face in retaining disability examiners and enhancing their expertise. Reflecting my concerns, that report went on to say that DDS directors reported that many examiners need additional training in key analytical areas that are critical to disability decision-making, including assessing credibility of medical information, evaluating applicants' symptoms, and analyzing applicants' ability to function. Finally, that report noted that under SSA's new approach for improving the disability determination process, these same knowledge and skill areas will be even more critical as DDS examiners take responsibility for evaluating only the more complex claims and as they are required to fully document and explain the basis for their decision.

There is a recurring theme among professional organizations that provide oversight to the SSA showing a persistent and uncorrected problem of inadequate training in the Social Security disability program. Every proficient business model contains an effective training program to address the training needs of its workforce. Could inadequate training be at the heart of why SSA's previous attempts at redesign failed to obtain most of its objectives? I don't think it's a stretch to say that inadequate training significantly contributed to those failures. Based on SSA's failures at prior attempts of redesign in which none of those initiatives successfully integrated a consistent and enhanced training program, it would be wise to consider the recommendations made by both the GAO and the SSAB; and attempt to formulate a better training program.

The SSA should establish an enhanced training program for examiners that emphasizes the clinical application of medical knowledge relating to medical impairments and their physiologic impact on a claimant's function. This training should be ongoing for old and new examiners, and should be provided for all levels of the decisionmaking process who must reason through a disability decision, including administrative law judges (ALJ).

If adjudicators at all levels aren't effectively taught the mental and physical issues relating to an impairment's impact on function, how can they be expected to accurately reason through a decision? I was amazed at the lack of emphasis the SSA and DDSs placed on this type of training, which has directly contributed to the inconsistency in disability decisions across the program. Some DDS leaders voiced concern that such ongoing examiner training given in more frequent increments would be disruptive as it would take examiners away from case development. That type of reasoning clearly reflects an emphasis on case development of quantity over quality.

Other DDS leaders told me they didn't want to offer more standardized training for fear of being accused by the SSA of typecasting impairments as it relates to an individual's function. They were afraid of stereotyping impairments with a set level of function, and let that fear override common sense when it came to the concept of standardized training. Training related to medical impairments and function can be standardized, yet presented in a way to allow the understanding of how it is possible for two claimants with the same impairment to be impacted differently from a functional standpoint. Training can be standardized, yet still incorporate development of critical thinking skills to encourage individualized adjudication of disability claims.

Not only have examiners been given inadequate training, but ALJs have been given even less medical training. I do not understand how ALJs are supposed to reason through a decision relating to medical issues based on a legal education. I acknowledge that a claim is supposed to be fully developed from a medical perspective by the time it reaches them, but by that time, months, if not years, have passed; and there may be a whole new slew of allegations or alleged worsening of prior allegations.

My experience with some ALJs was that they basically just started from scratch developing medical allegations by ordering multiple specialized exams. Some also ordered multiple diagnostic tests when they weren't even sure how to interpret the results. These practices are not cost effective. Some relied on medical experts for advice, but others did not. Calling in medical experts can be time consuming and adds to case processing times. This is partly due to finding a convenient time for a medical expert to be present, and providing time for a claimant's attorney to cross-examine the medical expert.

In some cases, ALJs just relied on what the treating physician opined as a level of residual function, regardless of whether the objective evidence supported the opinion. That is an example of selective interpretation of Process Unification rulings. But ALJs are just trying to do the best job they can, given the limitations and flaws inherent in the program.

What follows is a description of my proposed enhanced training program.

Develop clinically applicable training modules focused on the listings and most common types of impairments examiners see. Functional application of medical knowledge will allow examiners to better understand clinical concepts in claims, resulting in more efficient case development. Modules emphasizing “most common” cases let examiners become better skilled in the types of cases that make up the bulk of their work. Initiating training with “most common” scenarios provides a starting block for examiners from which they can start to establish critical thinking skills and hone these skills through repetition, i.e., by frequently seeing and reasoning through these types of cases. Modules focused on the listings let examiners become more proficient with use of the listings, which will facilitate “quick decisions” for applicants who are clearly disabled.

Examiners will learn to individualize case assessments when they begin to see that despite a possible common variable, the impairment, the impact of that impairment and its associated residual level of function can be vastly dissimilar for different individuals.

These modules should be implemented early in the training process to supplement the existing components of basic anatomy and physiology. Once a solid knowledge base is established, training modules can be advanced to more difficult and less frequently seen disease states and conditions.

Training modules should address what tests are necessary to adjudicate cases and explain why. Modules should also explain at what point in a claimant’s condition a test may become necessary and why. When examiners begin to understand the pathophysiology of a condition, it will be easier for them to remember what test result to look for in the medical records, or possibly to order with a Consultative Exam (CE). Rather than just providing a checklist of labs or tests for each disease or condition as is currently done in some DDSs, the reasoning for each test should be given to help the examiner associate the test with the condition, thus providing easier recall.

Training modules should address disease prognosis and possible expected outcomes of certain conditions, injuries, and surgeries, which is especially important in durational decisions.

Process Unification rulings should be integrated into these modules to demonstrate how to reason through a decision. Each ruling should be applied to case modules to enable writing a well-reasoned rationale.

Clinically based training should be extended to experienced examiners as continuing education. Hold monthly training updates in small groups so productivity won’t be disrupted. These training modules should focus on issues recognized as recurring problems found in Quality Assurance reviews.

Encourage better utilization of medical consultants through increased interaction with examiners. Establish a series of short lectures by different medical consultants on topics in which they are interested or specially trained. This lecture series should be given to more experienced examiners to supplement prior training by covering aspects of case development and adjudication that are more relevant to their level of experience and understanding.

I found that due to a high turnover of staff in DDSs, some examiners were prematurely promoted to supervisor positions. By default, this resulted in a small number of supervisors who lacked adequate medical knowledge to be able to sufficiently guide examiners in their unit on medical development of certain claims. Thus, this enhanced training program should encompass all levels of the decisionmaking process, including unit supervisors.

For this concept to work, it will be necessary to establish Operations support of regular and mandatory clinical training once newly trained examiners reach their units. Establishing an effective and consistent training program will improve the quality of decisions, establish consistency in decisionmaking, and save the program millions of dollars.

This training program should be introduced with the emphasis that this new style of learning, while taking a little extra effort up front, will result in examiners establishing control over a better product (a more accurate decision) through improved learning. While this concept will initially take time away from case development for some examiners, retaining well-trained and proficient examiners will be the reward for this investment.

This enhanced training program should be linked to a pride-based initiative through which the SSA can improve the morale of examiners and all other personnel. Improved morale will help decrease examiner turnover, which according to a recent GAO report, is twice that of other SSA employees.

Including the OHA in this initiative will help improve some of the issues contributing to the adversarial relationship between the SSA and the ALJs as they will see the SSA providing key support for their needs. This initiative will allow ALJs

to make better informed decisions regarding the medical aspects of disability claims. Ultimately, this concept will help revive the long-lost Process Unification initiative, which, in my opinion, is integral to maintaining the disability program's integrity in the eyes of the public.

SSA cannot afford to ignore the repeated warnings and suggestions made by individual stakeholders and professional organizations about making a strong ongoing training program the centerpiece to improve the disability determination process. SSA should start focusing on the core issue of why its attempts at redesign keep failing; and that core issue is training.

Sherman Oaks, California 91403
October 4, 2005

Honorable Members of the Social Security and Human Resources Subcommittees:

This letter is written by both Robert E. Lowenstein, Jr., and Janna Lowenstein, both attorneys of the law offices of Robert E. Lowenstein, Jr., APC. Our firm has been representing Social Security claimants in the Southern California area for the past 30 years. Mr. Lowenstein is a past president of the National Organization of Social Security Representatives. While our firm represents claimants from the initial application through the Federal court appellate process, the majority of our cases are hearings before Social Security Administrative Law Judges and appeals to the Social Security Administration's Appeals Council.

Although we commend the Commissioner for attempting to create a more efficient process to adjudicate claims both on the administrative and claimants' end, we would like to point out several of our concerns with the Commissioner's proposed changes. These concerns have to do with the addition of the Reviewing Official, the limitation of submitting medical evidence, the ability to reopen a previously determined or dismissed claim, and most importantly, the elimination of the appeals council. These concerns will be addressed as follows.

Reviewing Official

The proposed changes include eliminating the Reconsideration stage that is currently in place, and replacing this with a Reviewing Official (RO), who will either approve benefits or make a recommendation to deny benefits. The Commissioner proposes this change in an apparent attempt to streamline the system in order to make a decision in a shorter amount of time. However, this proposed change would most certainly increase the amount of time to receive a final decision for many of our clients and would do so for many claimants on a national level. Many of our clients live in geographic areas that are serviced by "prototype" District Offices that have already eliminated the Request for Reconsideration stage, allowing the claimant to appeal an Initial Denial directly to an Administrative Law Judge (ALJ). Adding the RO step back into the process would add another two to six months to get a decision that can still be appealed to an ALJ. The proposed changes also give the RO a presumption of correctness, as the ALJ must provide a rationale for not following the RO's recommended disallowance. We are told that these RO's will be attorneys "thoroughly trained in the policies and procedures of our disability determination process." These RO's will not hold hearings nor will they meet the claimants. Although they may be "thoroughly trained" they do not hold the same knowledge of an experienced ALJ who conducts hearings on a regular basis and is able to actually meet and observe the claimant in person. A decision that is to be considered presumptively correct cannot be made by a person who has not conducted a hearing with the ability for the claimant to testify or cross-examine any necessary witness under the rules, or has at the very least seen and observed the claimant. Additionally, ALJ's may be unduly prejudiced by the presumptive correctness of the RO's opinion, resulting in a compromise of the independence of the ALJ as set forth in the Administrative Procedures Act.

Submission of Evidence

Under the proposed rules, claimants would have the right to submit evidence only until 20 days prior to the hearing, with the opportunity to submit additional evidence only if the ALJ finds "good cause" for its late submission with limited allowances of what would constitute good cause. This change is not consistent with the Social Security Act, which states that the ALJ is to make a decision based on the evidence adduced at the hearing. The disallowance of evidence is also inconsistent

with the Act, which the Supreme Court has determined to be nonadversarial in nature.

This provision will also be extremely difficult to comply with in many cases, regardless of whether or not the claimant has representation. Claimants and representatives are limited by the medical care providers in the ability to obtain and submit evidence. For instance, many of our clients are low income, as would be all claimants seeking Supplemental Security Income, and can only be treated by county facilities. These facilities contract their own copy service and we are then left at the mercy of the facility to provide the documents. Even then, many times the documents do not include all of the requested material and we have to make another attempt to obtain these records. It is not uncommon that many doctors ignore our initial requests for records and we have to send second and third requests to obtain the claimant's medical records, much less obtain a detailed report from the doctor that would describe the claimant's functional ability, as is encouraged to obtain in the Regulations. Also, many of the claimants are unable to pay for these records or reports, especially on such short notice.

Also, many of the claimants have continuing diseases or impairments or a combination of impairments, and also impairments that cause other impairments as time goes by. As such, the claimant would be seeking continuous treatment for these problems and treatment does not necessarily stop 20 days prior to the hearing. In fact, the claimant would be penalized should he or she stop treating as the claimant would likely be denied benefits on the basis of failure to treat. There have been many occasions in our practice that a claimant has brought a record he or she received from the days just prior to the hearing due to recent treatment, which has explained a continuing condition the claimant has had, which have resulted in favorable determinations based on that information. On other occasions a claimant's memory is jogged at the hearing and suddenly they remember a treating source they had failed to make known to us previously. Take for example a person that has had ongoing severe abdominal pain, weakness, and fatigue that has been continually noted but not explained by one doctor and later explained by a consulting oncologist as cancer. The symptoms and limitations have not changed, yet this is now defined as cancer, a medically determinable impairment. As is noted earlier, only the ALJ has the authority to allow "late" evidence to come into the record, but there is no requirement that the ALJ accept any late evidence. If the proposed changes were to become the rule, should this oncologist's report not be admitted to the record due to the ALJ's disallowance of the "late" evidence, the claimant would likely be denied as there is not a "medically determinable impairment."

Our firm has often taken on representation for claimants who do not seek our assistance until after they have received a request for hearing. This is often due to the fact that the claimant did not understand the nature of the appeal process and the need for an attorney. We have also had claimants inform us that he or she had been told by an employee at his or her District Office or an agent answering the 800 number that they do not need an attorney or representation.

Under the proposed changes, claimants will have less than 25 days after receiving a notice of hearing to submit all medical records. This is assuming the Notice of Hearing actually gets to these claimants in the assumed number of postal days. Also, many claimants, especially those who are seeking Supplemental Security Income benefits, do not have a permanent address and are either moving in and out of friends and family members' homes or are homeless and do not often receive their mail in a timely fashion. Also, many claimants have a mental impairment or limited education that inhibits he or she from realizing the importance of the notice. Regardless, however, even with the full 25 days from the notice of hearing, as is noted above, it is extremely difficult to obtain medical records within such short amount of time from the medical care providers. There is no rule for the medical care providers to provide the records or reports within any given amount of time and the claimants and representatives are again at the mercy of the medical care providers.

We have also had claimants come to our office after they have been denied either in the initial stages or by an Administrative Law Judge who will say, "Why didn't they consider Dr. X's records?" Yet, these records are not in the claim file. The claimant will inevitably inform us that he or she believed that Social Security had Dr. X's records or that he or she believed Social Security would be obtaining all of the necessary records and reports, however, this is not often the case. Consider that they are not given copies of the medical records and other evidence obtained at the initial level and at the hearing level they are advised to arrive thirty minutes before the hearing to review their file. A denial notice reflects a doctor's name and date but not what was actually received. It may nearly be a letter saying the patient cannot be identified. The claimant would have no way of knowing this and he or she would think a report was received.

Reopening

The proposed changes also prohibit the ALJ from reopening a prior decision or claim based on new and material evidence showing that it is wrong. Taking the example used above, if an ALJ made an unfavorable decision based on the fact that the unexplained severe abdominal pain, weakness, and fatigue provided no actual medically determinable impairment, and if the Appeals Council received new and material evidence from the claimant's oncologist that was received after the hearing but prior to the decision, the Appeals Council would be able to either reverse the ALJ's decision or remand the case back to the ALJ for further development with instructions to include this new and material evidence. Such would not be the case here.

In addition, there are many instances where a case has been dismissed or not appealed but should later be reopened for good cause. We have seen many instances where a person has sought our assistance to appeal but have missed the deadline. Many of these claimants have a mental impairment and were not able to understand the nature of the appeals process, which was evidenced by multiple initial applications. Many other claimants missed their opportunity to appeal due to some nature of their impairment, be it mental in that they did not want to keep fighting for their benefits due because of depression, or because they were physically incapacitated or in the hospital during the appeal period. We have also seen claimants be denied their right to appeal when the claimant did not receive the notice of disapproval in the mail. Unfortunately, some are misdirected by Social Security personnel to file a new claim instead of appealing. Whatever the case may be, the rules to reopen a prior decision or claim should not be so limited as to allow only 6 months with such limiting situations to reopen.

Another reason to reopen a claim is when a claim is dismissed due to the claimant's failure to appear at the hearing. When a claimant does not show for the hearing, the ALJ issues an order to show cause for failure to appear, which is mailed to the address that the notice of hearing was sent to. However, as is noted above, we have seen many instances where our office has informed Social Security through the Office of Hearings and Appeals that the claimant has moved and have provided the new address, but the notices are sent to the old address. We have also seen instances where Social Security has made an error on the address. Fortunately for those claimants who are represented, the representative is usually able to make sure the claimant is aware of the hearing date and time, however, for those unrepresented claimants, they would have no idea of the hearing date and would not be able to answer an order to show cause because it was also sent to a wrong address. Some ALJ's simply dismiss the claim for being a few minutes late or missing the hearing without even sending an order to show cause forgetting that the claimant may well have been unable to appear because of illness or transportation problems at the last moment, which were unavoidable.

The failure to reopen a claim based on new and material evidence can also be the end of the road for a claimant who has passed his or her date last insured. In Title II claims, a claimant is only insured for a certain period of time and can only collect benefits under this title if he or she is found to be disabled prior to this date. Using the above example, with the claimant who was denied benefits because of no medically determinable impairment and no ability to submit the late evidence that identified the symptoms as cancer, and assuming the claimant had a date last insured of December 31, 2003, if the decision was issued in January of 2004, the claimant would not be able to reopen this claim in order to submit this additional evidence and collect benefits. Under the proposed changes, the claimant would have to file a new application for a period that was not previously considered. However, in this instance, a new application would not help this claimant as the previous decision would be held under *res judicata* and a new timeframe would not be within his or her date last insured. This person would be barred from collecting the benefits he or she is due.

Appeals Council

The most concerning aspect of the Commissioner's proposed changes is the idea of eliminating the Appeals Council, leaving claimants who are not satisfied with the ALJ's decision the only option to appeal to the District Court. The Commissioner intends to replace the Appeals Council with the Disability Review Board (DRB). The DRB would have its own standards of selecting cases for review and would not allow the opportunity for a claimant to appeal to it. The DRB can affirm, reverse, or modify an ALJ decision, whether favorable or unfavorable, if there is an error of law. But if there is a factual error, the DRB must remand to the ALJ. If the DRB reverses a claimant-favorable ALJ decision, that claimant must proceed to federal court to fight for the benefits awarded by the ALJ. If the DRB selects a case, a no-

tice will be included along with the ALJ decision. To submit new evidence to the DRB, the same strict post-ALJ decision submission requirements apply. The DRB may “invite” a brief, but unless the DRB extends this invitation, the claimant must ask permission within ten days of receipt of the Review Notice to submit a brief. Again, there are often problems with receiving notices in a timely fashion, especially if the claimant is unrepresented. If the DRB grants permission to submit a brief, it may not exceed three pages, regardless of the case’s complexity. In our office, we have had files that are more than six inches thick of only medical records. The proposed regulation provides, “If you file a written statement in a claim and the Board has not asked or allowed you to submit one, the Board will not consider the written statement and will return it to you without making it a part of the record.” Proposed § 405.425(b)(2). These restrictions are not within the spirit of the Social Security Act, which is inquisitorial, rather than adversarial in nature.

The Appeals Council has also served as a good screen for determining what cases should be taken to the District Court for review. If the claimant receives an unfavorable decision that appears to have either legal or factual error, or if the claimant has new and material evidence that would change the outcome of the decision had it been available prior to the decision being issued, we will file an appeal to the Appeals Council. When the AC issues an order that has explanation in it, there are times that this explanation will enable us to see the case in a different light and determine not to further the appeal to District Court. However, without such a screen, the claimant would be forced to appeal directly to the District Court. The proposed changes merely shifts to the federal courts the responsibility for correcting tens of thousands of incorrect ALJ decisions each year. From the perspective of claimants the true average time for adjudication does not decrease with the proposed changes. The elimination of the AC merely shifts the responsibility for the correction of ALJ errors.

The timeframe for the adjudication will be much longer. The current process at the Appeals Council involves submitting a request for review and submitting a brief summarizing the errors in the decision. Oftentimes, a hearing tape and/or exhibits are requested prior to submitting this final brief. Much of the delay that the Commissioner has accounted for in her “worst-case” timeframe accounts for finding and/or transcribing the hearing tape and the records. However, the Commissioner has already devised a plan that would greatly eliminate this delay. The use of the electronic folder and digital copy of the hearing would allow the Appeals Council to retrieve and even send this information in minutes, rather than months or even years. By taking this appeal to District Court, a case that may have only taken an attorney a few hours to review the decision and summarize the errors, will now take 20–40 hours reviewing the case and facts, the law, and preparing the argument for Court. Added to this time will be the defendant’s time for answering the claimant’s motion and the time for the claimant’s response to the defendant. As it is practiced in our local District Court, the Commissioner’s attorneys are granted an extension without any explanation as it is known how many cases are currently in the system. Add to this all the cases that would have been screened out by the Appeals Council either in their own reversal or remand or by an explanation as to why the ALJ’s decision was in fact correct, and the timeframe for adjudicating the claim in District Court will be exponentially increased.

The elimination of the Appeals Council also establishes the need for a claimant to pay a \$250 filing fee that may be waived based on their financial status. However, an unrepresented claimant may not be aware of this rule and may not ask for the waiver. In other instances, claimants, either represented or not may be disinclined to appeal a decision, even if there are grave errors in the decision because of this filing fee.

There is also the concern that unrepresented claimants would be unable to find representation to take their claim to District Court. There is not a large population of Social Security attorneys. Even less are the Social Security attorneys who handle cases beyond the administrative level and into the District Court or above. With the exponential increase in cases needing to be taken to Federal Court, the relatively few attorneys that handle Social Security appeal cases would be unable to accept all of these cases as they require much more time. This would lead to the unrepresented claimants or claimants who were represented by non-attorney representatives or attorneys who do not handle appellate matters without representation in Federal Court. Although a claimant may proceed without legal representation, he or she does not likely have the training and knowledge to point out the legal errors in the decision and provide legal rationale to support his or her claim.

Federal litigation is costly both to the Agency and to claimants. With the elimination of the AC, the Agency will have increased costs due to its need for more attorneys to defend its decisions under 42 U.S.C. 405(g). The Agency will also pay

more attorney fees to claimants and claimants' attorneys under the Equal Access to Justice Act. See 28 U.S.C. 2412(d). Additionally, as time will be extended for adjudication, claimants themselves will share more of their deserved past-due benefits with their attorneys when they pay those attorneys pursuant to a court order. See 42 U.S.C. 406(b).

Conclusion

Although it is honorable that the Commissioner of Social Security is attempting to streamline the system to make it more efficient for both the Agency and the claimants, the proposed changes contain many obstacles that would in fact provide the opposite result the Commissioner intended. We urge the Subcommittees to work with the Commissioner to amend the proposed regulations so that the rights of claimants are fully protected and to keep in mind these issues that are not in the spirit of the Social Security Act. Thank you for your time and consideration.

Very Truly Yours,

Robert E. Lowenstein, Jr.
Janna Lowenstein

Statement of James E. Marshall, AFGE Council 215, Falls Church, Virginia

Chairman Shaw, Chairman Herger and Members of the Social Security and Human Resources Subcommittees:

I respectfully submit this statement regarding Commissioner Jo Anne B. Barnhart's changes for improving the disability process. My name is James E. Marshall. I have been employed by the Social Security Administration for 47 years and have been an employee of the Office of Hearings and Appeals for 33½ years at OHA Headquarters in Falls Church, Virginia. I am also the President of AFGE Council 215, National Council of Social Security Administration OHA Locals, which represents approximately 5,000 employees in 135 hearing offices across the United States, as well as employees at OHA Headquarters in Falls Church, Virginia, and employees at SSA Headquarters in Baltimore, Maryland.

This statement is being presented based on my review of the Agency's publication in the Federal Register on July 27, 2005. As you are aware, in September, 2003, Commissioner Barnhart announced her plan to reform the disability process and her intent to implement her proposals through the regulatory process. On July 27, 2005, the Social Security Administration published in the Federal Register Commissioner Barnhart's changes for improving the disability process. It is vital to note that the prerequisite for these changes is contingent on the total conversion from a paper claims processing system to an electronic disability claims adjudication process.

At the outset, while I fully support the Commissioner's idea to improve the disability process and was committed to work with her regarding these complex disability improvement issues, she elected, for reasons known only to her, not to include me in any discussions. As the exclusive representative for approximately 5,000 employees in the Office of Hearings and Appeals, you would have thought I would have been involved in discussions regarding the new disability process prior to publication in the Federal Register.

Now, turning to the Commissioner's Proposed Rulemaking for Adjudicating Disability Claims, I fully support the establishment of a Quick Disability Determination Process, but believe that a new position of Technical Expert for Disability should be created in the Social Security field offices to screen and effectuate the adjudication of these claims. Such new position would clearly provide for minimal processing time, increase the level of service the Agency provides and will effectively accomplish the Agency's goals of outstanding customer service.

The Commissioner's proposed improvement plan establishes the creation of Federal Expert Units to assist adjudicators throughout the country to ensure that the right decision is made at the lowest level of adjudication. I believe the composition of these Federal Expert Units should be Federal employees rather than contractors. In this regard, I note that if the Agency elects to staff these units with medical, psychological and vocational expert contractors, under recent IRS rulings, there may be significant legal ramifications because the proposal tends to support an employer/employee relationship. Additionally, while the proposal does not indicate or suggest the location of these units and/or the number and types of experts that will comprise each unit, each adjudicator should have easy access to these experts within the different national time zones and a significant number of experts should be made available during all working hours. It would appear that the cost for salaries, office

space and possibly support staff would give rise to a substantial increase in the Agency's overall budget.

I have no comment regarding the Agency's intent to terminate the reconsideration step in the disability adjudication process.

The Commissioner's proposal establishes a Reviewing Official to review the State Agency's initial determination. While the Commissioner believes that only attorneys are ideally suited to perform the Reviewing Official functions, such as garnering requested evidence to compile a complete case record and drafting a well-supported legally sound decision, I totally disagree. I further disagree that by using attorneys as Reviewing Officials, there will be improvement in the level of confidence that applicants, members of the public, Administrative Law Judges and other interested parties have regarding the integrity of our first level of administrative review, especially noting such conclusion is contrary to providing outstanding public service. In this regard, I note that the Agency's plan to hire an unspecified number of attorneys to serve as Federal Reviewing Officials will be extremely costly and create a very legalistic review of claims. While the Agency plans to thoroughly train these newly hired attorneys in the policies and procedures of its disability determination process, it is reasonable to believe that the cost of training and loss of productivity for the first 12 months of operation will create an enormous backlog of cases that will deny claimants an expeditious review for several years in the future. Also, it is reasonable to believe that with such a process, claimants will most likely obtain legal representation for this review rather than being unrepresented if the Reviewing Official is either an attorney or non-attorney. If this does occur, claimants will have less retroactive benefits because a portion will be paid to attorneys unnecessarily. Based on the projected workloads and the Agency's staffing requirements for attorneys to serve as Reviewing Officials, I submit it will require the hiring and training of approximately 5,000 attorneys to conduct this review, as well as obtaining office space and equipment for each of these newly hired employees. As an alternative to using only attorneys, I note the Agency has thousands of highly skilled non-attorney employees with disability expertise who could conduct this review of the claims and provide legally sound decisions. Examples of such positions are Paralegal and Disability Analysts within OHA, Disability Examiners and DQB Analysts, noting that many employees in these positions will be displaced by the changes in the Agency's proposal.

Further, although not addressed in the Agency's proposal, I submit that the Reviewing Official will need staff support, including possibly a Junior Paralegal position, to assist in obtaining additional evidence, drafting decisions for review and performing other similar duties to ensure that the Reviewing Official has the ability to meet the workload demands of the position and provide world class service to the public he/she serves.

In staffing the Reviewing Official position with all attorneys as contemplated by the Agency, I note that approximately 1,000 attorney decision writers in OHA may apply for this job and if selected, it will create a massive void of decision writers within the OHA hearing offices to assist the Administrative Law Judges. The Agency would then be required to hire and train new decision writers who presumably would be paralegals because all the attorneys would have been hired as Reviewing Officials. The decision writing position of Paralegal is essentially a two year developmental position for an employee to be fully productive and such action would obviously create a massive backlog of cases at the hearing level, as well as establishing a significant delay in processing cases far and beyond what the Agency has experienced in the past.

Here, it is vital to note that because of a recent IRS ruling regarding the Contract Hearing Reporter, the processing of claims in OHA hearing offices may be significantly affected because of additional duties that support staff will be required to perform which were previously performed by the Contract Hearing Reporter. As such, in the absence of a significant increase in support staff hiring in OHA hearing offices, it appears there will be a significant reduction in the number of dispositions for Administrative Law Judges and an increase in backlog before the change in the disability process as contemplated by the proposed Regulations is implemented. The Agency has made no attempt to budget this additional workload by Federal employees with an increase of FTEs.

I fully support continuation of preserving the claimant's right to a de novo hearing which is conducted by the Administrative Law Judge. However, I strongly oppose the Agency's time limits for closing the record on the basis that while the timeline may possibly result in a slight improvement in processing time for the Agency to meet unrealistic goals, the overall effect will clearly deny many claimants a full and fair opportunity to establish his/her disability within the Agency's claim adjudicative process. I believe that the closing of the record should be with the issuance of the

Administrative Law Judge's decision and that the Agency can meet its legislative commitment to claimants and still fulfill a significant improvement in the processing time of claims with reduced cost.

I totally oppose the elimination of the claimant's right to request a review of a hearing decision by the Appeals Council and note that such review is at no cost to the claimant and provides for fair and equitable adjudicative relief. While I note that the Appeals Council has been subject to considerable criticism over the past several years, a review of this process since 2003 clearly establishes real improvement in the processing of claims with consistent corrective relief to approximately 30% of the claimants who request review of the Administrative Law Judge's decisions. Such improvement has been based on various changes at the hearing level, but most significantly, because each employee who works at the Appeals Council has an "I can do" attitude. I note that at the present time, the Appeals Council has a manageable claim workload with less staff and that the new digital recording of hearings and the implementation of the electronic claim files will streamline the appeals process so that the timeline suggested for the Decision Review Board could be met by retaining the Appeals Council review process. With such improvements proposed at lower levels of adjudication, the Appeals Council should be allowed to continue in accordance with the regulatory process and I note there should be a significant decrease in the filing of civil actions because both the claimant and the legal profession will accept a decision by the Appeals Council as the final adjudication of a claim. To eliminate the Appeals Council and essentially replace it with a Decision Review Board would create a self-serving, non-effective function and I submit that as a result thereof, there will be a substantial increase in civil action filings for many years to come. This will result in substantial staffing increases of highly paid professionals to address the massive number of court remands. As anyone can see, rather than having a claimant friendly process, the proposal of elimination of the Appeals Council and establishment of a Decision Review Board clearly reflects a very legalistic, adversarial process which can be viewed as substantially decreasing service to the American public.

In closing, I thank you for the opportunity to submit this statement for appropriate consideration and action regarding the Commissioner's proposed regulatory changes to the disability process within the Agency.

Decatur, Georgia 30030
October 4, 2005

The Honorable Jim McCrery
Chairman, Subcommittee on Social Security

The Honorable Wally Herger
Chairman, Subcommittee on Human Resources

Dear Mr. Chairman McCrery and Mr. Chairman Herger:

I am writing to thank you for holding a hearing on the Commissioner's proposed changes to the disability process, and to give my comments from the perspective of a lawyer who has helped disabled people seeking benefits for 28 years. I am concerned that the poor and sick will be harmed, not helped, by the proposed changes.

The Commissioner deserves praise for considering the delays experienced by disability claimants deplorable. She calculates that it takes an average of 1,153 days to pursue a disability claim through all stages of administrative appeals. I had great hope that she would propose changes effecting a real improvement. I am disappointed that her proposal attempts to gain improvements in the speed of the process primarily by eliminating rights which disabled claimants now enjoy. The plan would increase the speed of the process by limiting the time claimants have to submit evidence, denying claimants the ability to submit evidence which becomes available late, denying claimants the right to ask that decisions be reopened when new evidence shows the decision was wrong, and denying claimants the right to ask for a brief review of a hearing decision without having to incur the costs and other burdens of a court appeal. I urge you to carefully follow the Commissioner's proposals to assure that the least powerful and poorest segment of our society—the disabled—are protected from a system producing fast but unfair decisions.

I have been helping disabled people get Social Security disability long enough to remember that the delays in the system were not always untenable as they are today. The delays began to increase when staff reductions were made in the early 1980's. The delays were made worse when the number of disability claims began

to rise due to the aging of the baby-boom generation, and the Social Security Administration did not increase staffing level proportionately. While no one wants wasteful government spending, even with adequate staffing the Social Security Administration adjudicated claims in a very cost-effective manner.

The Commissioner's proposals acknowledge that the submission of medical evidence is one reason for delays in the process, but this system was able to issue decisions promptly without severe restrictions on the submission of evidence before understaffing became a fact of life at the Administration. For years one of the major problems of my practice was that hearing decisions would be issued before my clients had been out of work for twelve months, so they had not met the duration requirement in the Act yet. What changed after that? The only significant change has been the increased workload expected of individual employees of the Social Security Administration.

The Commissioner's proposal to eliminate a claimant's right to submit evidence up to and at the hearing appears to be inconsistent with the Social Security Act, which requires the Commissioner to make a decision based upon evidence adduced at a hearing. The Commissioner's proposal to eliminate disabled claimant's ability to ask for a decision to be reconsidered when new evidence is obtained showing a decision was wrong is unfair, and would not contribute significantly to the speed of the process. It also appears at odds with Congressional intent, because Congress intended that introducing new evidence be more difficult in court than before the Administration, but still permitted consideration of new evidence for good cause. The Commissioner proposes eliminating disabled claimant's ability to have new evidence considered for any reason. Since Congress required good cause to create a stricter standard for a court to consider new evidence, the standard for considering new evidence by the Administration must be more liberal than the standard at the court level.

The Commissioner will miss an important opportunity to speed up the process if the unproductive part of the process is not eliminated. Cases are delayed two to four months, sometimes longer, at the Reconsideration level, but few decisions are changed at this level. There is no reason to keep it, and even less reason to rename it and make it more complex. The proposal will require a much more detailed rationale, but will not bring any additional value to the table. The claimant will not interact with the Reviewing Official, nor will the representative. The resources devoted to this level will be wasted, and the claimant's decision will simply be delayed.

The Commissioner is wrong when she says the Appeals Council does not "intercept large numbers of claims that do not withstand Federal district court review." While it may be true that the courts are remanding more than 50% of the cases appealed there, that would be 7,574 court remands in 2004. During the same time, the Appeals Council remanded 23,266 cases, or roughly three times the number remanded by the courts. The Commissioner's other justification for elimination of the Appeals Council is the length of time it takes to make a decision, but I am currently receiving decisions from the Appeals Council in about three months, as I did in the 1970's and 1980's. This demonstrates that the delays at the Appeals Council are caused by staffing levels assigned to it, not be any feature of its design.

One thing the Commissioner's proposal does not mention which will become evidence if it goes into effect is the drastically-increased cost caused by shifting thousands of cases from the Appeals Council into the courts. The Appeals Council has a couple dozen judges, and several hundred analysts, for the entire country, each working on hundreds of cases a year. If even a small percentage of these cases proceed into court, the Administration will need to hire more lawyers to represent the Administration in court, and the courts will need more judges and support staff. Many of these cases will result in the government paying attorney's fees under the Equal Access to Justice Act. The elimination of the Appeals Council has been tested by the Commissioner, but she has not produced any evidence from her pilot. It is reasonable to assume the data which has not been produced does not support the proposed changes.

The Commissioner's proposals make it appear that disabled claimants are responsible for all the delays. Nothing in the proposal puts any time limits on the Administration; all the limitations are on disabled people. But the Administration doesn't need protection from the disabled, it's the other way around. Your office gets numerous calls about the delays in the process. Ask them if they caused the delays themselves. Or ask around your own family and friends; everyone is touched by disability, including every voter in every district.

I urge the Congress to carefully watch the Commissioner's changes to assure that the intent of the Social Security Act is not lost. Let's not throw the baby out with the bath water. The disabled are—because of their disabilities—the poorest segment of our society, and the least able to shoulder the burden of making a government

agency operate efficiently. Please ask the Commissioner to strive to improve the efficiency of the Administration rather than reducing the access disabled claimants have to the system.

Sincerely,

Charles L. Martin

Statement of Michael Miskowiec, Charlestown, West Virginia

Dear Sir or Madam:

Thank you for the opportunity to comment on the proposed rules entitled "Administrative Review Process for Adjudicating Initial Disability Claims." I have reviewed many of the comments which have been submitted through the Social Security website and watched part of the House Ways and Means Social Security Subcommittee on September 27, 2005. I will not begin these comments with praise for the effort to streamline the disability determination process because the egregious violations of the procedural and substantive rights of claimants for Social Security and Supplemental Security Income disability benefits resulting from these proposed regulations outweigh any efficiency these regulations may bring to the disability determination process.

I have been representing claimants before the Social Security Administration for 23 years. Although my practice is predominantly in one Office of Hearings and Appeals (Charleston, West Virginia), I have frequent contact with the Huntington, West Virginia, Morgantown, West Virginia and Charlottesville, Virginia Offices of Hearings and Appeals. Finally, I am very active in the West Virginia State Bar Committee on Social Security. Therefore, I believe my observations of the current disability determination process are well-founded in experience.

1. I challenge the assumptions underlying the notice of proposed rulemaking. In the proposed rules, a new "quick disability determination" process is proposed on the supposition that these regulatory changes are necessary in order to provide quick decisions for individuals "who are obviously disabled" (70 Fed. Reg. at 43594).

The Commissioner's regulations currently allow a finding of "presumptive disability" in SSI claims when the claimant is obviously disabled. If the Commissioner has reached the conclusion that claims of the obviously disabled are not being processed quickly enough, the Commissioner should first investigate whether the presumptive disability regulations are being adequately applied by the state disability determination services. If not, further training and oversight by the Commissioner is warranted.

2. The proposed regulations also work on the assumption that "the late submission of evidence to the Administrative Law Judge significantly impedes their ability to issue hearing decisions in a timelier manner." 70 Fed. Reg. 43596.

While I admit that it takes an unreasonable period of time to receive a decision from an Administrative Law Judge, I do not believe this is in any significant way the result of submission of evidence late in the process. I believe the two major reasons for delay at the hearing level are the increased backlogs that were generated due to the improvident HPI experiment which divested local accountability from the hearing offices and the failure of the Administration to hire additional support staff for the new class of Administrative Law Judges recently hired.

Administrative Law Judges have frequently told me that there is inadequate staff to work up files for hearings and to draft decisions after hearings are scheduled. The Commissioner's proposed regulations will not resolve these problems. Therefore, the Commissioner's proposal to allow Administrative Law Judges to reject evidence tendered less than 20 days before the hearing will not expedite the determination process but will prevent the Commissioner from making a disability determination based on a complete record.

3. Proposed rule 20 C.F.R. § 405.331 which allows Administrative Law Judges to refuse to consider evidence tendered less than twenty (20) days before the hearing should not be adopted for several reasons.

A. This proposal suggests that the testimony of the claimant and other witnesses is not evidence. While the Commissioner has not proposed doing away with the personal hearing before the Administrative Law Judge, suggesting that "evidence" cannot be submitted twenty days before the hearing leaves open the question whether the staff who drafted this proposal consider claimant testimony to be "evidence." In my experience, many issues first come to light at the Administrative Law Judge hearing, such as illiteracy, untreated mental illness, and severe pain which precludes an individual from performing work on an eight-hour-a-day, five-day-a-week

basis. Therefore, the testimony of the claimant at a hearing is entitled to the same evidentiary consideration as documentary medical evidence.

B. The Commissioner's proposed rule § 405.331 violates the Social Security Act. 42 U.S.C. § 405(b)(1) provides that the Commissioner must afford a claimant notice and an opportunity for a hearing and, if a hearing is held, the decision must be based on "evidence adduced at the hearing." This proposed regulation would unlawfully restrict the record to evidence adduced no less than twenty days before the hearing.

C. Proposed rule § 405.331 ignores the fact that the Commissioner has a duty to assist the claimant in establishing his claim. If existing, relevant evidence is not in the record at the time the claimant requests a hearing, it is because the disability determination service did not or could not obtain the evidence. To suggest that a claimant, perhaps unrepresented, is somehow in a better position than the agency to secure this evidence on as little as twenty five days' notice is unrealistic.

4. Proposed rule 20 C.F.R. § 405.331 fails to give adequate guidance to the Administrative Law Judge to determine whether the claimant has demonstrated good cause for submitting evidence less than twenty days before the hearing. Section 405.331 references § 405.20 for the definition of good cause. Section 405.20 contains no examples or discussion of circumstances that would be good cause for failure to submit evidence.

5. The procedure for the Disability Review Board to review Administrative Law Judge's decisions is unfair and violates the claimant's right to due process. The Decision Review Board would be allowed to review favorable Administrative Law Judge decisions based on an unpublished algorithm that supposedly identifies "error prone" cases. Furthermore, the Disability Review Board can conduct an "investigation," possibly including new medical development to rebut the findings of the Administrative Law Judge.

On the other hand, the claimant will have no right to submit evidence. The claimant loses his opportunity for an administrative appeal of an unfavorable Administrative Law Judge decision. Not only does this procedure deprive claimants of due process, but it will impinge on the independence of Administrative Law Judges.

6. Finally, the proposed rules intend to do away with the claimant's right to seek reopening of a final determination for new and material evidence. The rules suggest that a claimant can file a new application if they have new and material evidence. This suggestion shows either ignorance of the disability determination process or a callous misstatement of the law. If a claimant files a new application, principles of administrative finality and *res judicata* would prohibit the new decisionmaker from awarding benefits prior to the earlier unappealed decision. Furthermore, if the claimant's insured status has expired while the prior claim was pending, the new and material evidence could not be related to a Social Security disability claim.

Preserving an adjudicator's discretion to reopen a final determination based on new and material evidence is essential to the nonadversarial nature of Social Security adjudication process.

In conclusion, it is questionable that the Commissioner's proposed regulations will significantly improve timely claims processing. But there is no question that the proposed regulations will make it far less likely that the Commissioner will issue accurate decisions on legitimate disability claims. Therefore, the proposed regulations should not be adopted.

Respectfully submitted,

Michael Miskowicz

Joint Statement of The National Health Care for the Homeless Council and The National Law Center on Homelessness & Poverty

Advocates for people experiencing homelessness—including the National Health Care for the Homeless Council (www.nhchc.org) and the National Law Center on Homelessness & Poverty (www.nlchp.org)—offer the following statement on the proposed rule of the Social Security Administration on the Administrative Review Process for Adjudicating Initial Disability Claims (20 CFR Parts 404, 405, 416 and 422):

Disability precipitates and prolongs homelessness.¹ Homeless people suffer extraordinary and well-documented health risks associated with poverty, over-

¹A "homeless individual" is defined in section 330(h)(5)(A) of the Public Health Service Act as "an individual who lacks housing (without regard to whether the individual is a member of

crowding, and poor access to health care. People without homes are mercilessly exposed to the elements, to violence, and to communicable diseases and parasitic infestations. Circulatory, dermatological, and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses. Stresses associated with homelessness also reduce resistance to disease and account for the emergence of some mental illnesses. Homeless people experience illnesses at three to six times the rates experienced by housed people.²

There is increasing awareness of the role of medical impairment and disability in precipitating and prolonging homelessness. The fact that people with disabilities constitute the “chronically homeless” population in America is extremely troubling. Any national strategy to end and prevent homelessness must include adequate financial supports to enable persons with disabilities which limit their capacity to earn sufficient income through employment to secure housing and meet other basic needs, including health care.

Disability assistance can mitigate health risks associated with homelessness. The most important sources of assistance for Americans with disabilities are two Federal programs administered by the Social Security Administration (SSA)—Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI and SSDI constitute a safety net for persons with disabilities, providing both cash assistance and eligibility for health insurance under Medicaid and/or Medicare.

Persons who qualify for SSI/SSDI are more likely than others to obtain available low-cost housing and receive priority for certain types of housing. By increasing access to housing and health care, disability benefits can help to mitigate health risks associated with homelessness, facilitate recovery, improve quality of life for many homeless people, and help them to resolve their homelessness.

The timely receipt of SSI or SSDI benefits dramatically improves access to food and stable housing. Both the Medicaid coverage that accompanies the receipt of SSI and the Medicare benefits that follow receipt of SSDI improve access to comprehensive health care, including mental health services and addiction treatment. Homeless individuals with disabilities who receive comprehensive health services, intensive case management, and the means to meet their subsistence needs are much more likely to achieve stabilization, end their homelessness, and eventually participate in gainful employment. Expedited SSI/SSDI benefits are therefore extremely important to protect and increase their economic security.

Declining social supports and SSI/SSDI eligibility barriers increase risk for prolonged homelessness. Welfare reform efforts and other benefit retractions of the past two decades have left an increasing number of individuals and families at risk of homelessness. Time limits and punitive consequences for noncompliance with welfare guidelines, as well as the narrowing of eligibility criteria to exclude substance use disorders as a basis for disability, have resulted in the elimination of social supports for extremely vulnerable individuals and families.

Lacking access to Federal income support and public health insurance, single adults—by far the majority of clients at most Health Care for the Homeless projects—are forced to rely on various State-only programs, which have been cut back or eliminated in most states over the past 20 years. Federal and State disability programs and vocational rehabilitation services are similarly limited. Restricted access to SSI/SSDI benefits is exacerbated by average waiting periods of one-to-three years between application and eligibility determination, and significantly higher denial rates for homeless claimants.

People experiencing homelessness often fail to obtain SSDI or SSI despite the high likelihood that they would meet eligibility requirements, due to a variety of system barriers. Obstacles include lack of access to health services, insufficient documentation of functional impairments, remote application offices, lack of transportation, and complex application processes. Often barriers are intensified by the functional impairments of mental illness and the lack of personal stability necessary to see a complex application process through to completion. A national study of homeless assistance providers and their clients conducted in 1996 found that only 11%

a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.” . . . A recognition of the instability of an individual’s living arrangement is critical to the definition of homelessness.” (Principles of Practice for Health Care for the Homeless grantees, Bureau of Primary Health Care Program Assistance Letter 99-12, March 1, 1999).

²Wright JD. Poor People, Poor Health: The health status of the homeless. In: Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton & Co., 1990: 15-31.

of homeless service users received SSI and 8% qualified for SSDI.³ Local studies conducted since then suggest that homeless disability claimants are denied benefits at significantly higher rates than other claimants.

A review of disability claims submitted to the DDS in Boston from July 2002 to September 2004 revealed that SSI/SSDI denials were 2.3 times more common than approvals for homeless individuals, while denials for housed claimants were 1.5 times more common than approvals.⁴ An earlier study by the Homeless Subcommittee of the Massachusetts DDS Advisory Committee had found that 33%–37% of unsuccessful disability claims submitted by homeless persons (over a nine month period in 1998–99) were denied for lack of sufficient medical evidence or failure to keep appointments for a consultative examination.⁵

The Federal Health Care for the Homeless (HCH) program, administered by the Health Resources and Services Administration, awards grants to 177 health centers that provide primary care and related services to persons experiencing homelessness. HCH providers estimated that as many as 31%–84% of their uninsured homeless clients served in FY 2000 had mental or physical impairments that should have qualified them for SSI and Medicaid. Advocates attested that SSI or SSDI benefits might have been obtained for these clients with aggressive application assistance, patient advocacy, and case management.⁶

Comments on the Proposed Rule

We strongly support efforts to reduce unnecessary delays for claimants and make disability determinations more efficient, so long as the new procedural requirements do not unfairly prevent those meeting the statutory definition of disability from obtaining benefits. Our overarching concern about the proposed rule is that in attempting to simplify the disability determination process for adjudicators, it may make the process more complex and harder to negotiate for claimants—especially for those who are homeless.

1. Quick Disability Determination Process

While the proposed process may expedite benefits for some claimants, it is unlikely to alleviate existing barriers for many of those who are homeless.

- **Obtaining medical evidence of impairments for homeless claimants within the 20-day limit may be impossible.** Medical records of claimants who have seen multiple providers in several jurisdictions may not be readily available. This requirement would be especially difficult for persons who do not meet or equal a medical Listing, for those with mental illness or other impairments with symptoms that are difficult to document, and for those with learning problems secondary to language barriers, educational limitations, or undiagnosed learning disabilities limiting capacity to work. Criteria currently used to approve Presumptive Disability exclude many chronically homeless people whose severe medical impairments are acknowledged, if not yet completely documented. We are concerned that the same might be true of Quick Disability.
- **Expedited disability determination is needed for all homeless claimants.** For the reasons just cited, most homeless claimants would continue to rely on the regular disability determination process. Would quicker approval of more cases with well-documented claims enable faster and more accurate decisions on homeless claims considered during the regular disability determination process? This is one of our most serious concerns.
- **We recommend that homelessness be considered as a factor in disability determinations, at every level of consideration.** All claims filed by homeless persons should be flagged, at all levels of consideration, to trigger expedited disability determination due to urgency of need. This would be consistent with the President's goal of ending chronic homelessness. The fact that all disability claims filed by hurricane Katrina survivors are flagged for expedited consideration demonstrates that the proposed process is feasible. Social

³Burt, Martha, et al. *Homelessness: Programs and the People They Serve: Summary Report—Findings of the National Survey of Homeless Assistance Providers and Clients*, HUD Technical Report. Washington, DC: The Urban Institute, 1999: http://www.huduser.org/Publications/pdf/home_tech/tchap-05.pdf.

⁴O'Connell JJ, Quick PD, Zevin BD, Post PA (Ed.). *Documenting Disability: Simple Strategies for Medical Providers*. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2004, p. 7: <http://www.nhchc.org/DocumentingDisability.pdf>.

⁵Post, Patricia A. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*. Nashville, TN: The National Health Care for the Homeless Council, 2001, p. 61: <http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf>.

⁶Ibid, pp. 72–73.

Security, in special circumstances, has long flagged cases; the agency has the administrative capacity to promptly implement such a process.

2. Review of Initial Determinations by a Reviewing Official

- **Under the proposed process, claimants would have no opportunity for communication with the Reviewing Official (RO).** When adjudicators have the opportunity to communicate directly with claimants, it gives them a more complete basis for determining disability. The explicit objective of this policy is “to ensure to the maximum extent possible the accuracy and consistency—and thus the fairness—of determinations made at the front end of the process.” However, a paper-only review, with no opportunity for communication between the RO and the claimant will not achieve this objective.

3. Administrative Law Judge Hearing

We are concerned that the proposed process may impose a disproportionate burden for homeless claimants and prevent administrative law judges from making accurate decisions.

- **Time limit for submitting evidence before an ALJ hearing:** The proposed rule would require that evidence be submitted 20 days before an ALJ hearing. This short timeframe would limit the ability of advocates to take on cases for homeless claimants, which often require significantly more time to gather evidence. The mobility of claimants lacking residential stability, the complex medical and psychosocial problems characteristic of homeless people, and their limited access to health services present extraordinary challenges in gathering sufficient medical evidence of functional impairments.
- **Requirement that ALJ address RO decision in a *de novo* hearing:** This seems to undercut the ability of an ALJ to have a *de novo* hearing. Is it realistic to expect that this will lead to impartial new decisions? The main purpose of a *de novo* hearing is to take a fresh look at all evidence. Our concern is that looking at prior evidence already judged to be insufficient might bias this process.
- **Reopening a prior application:** Under the current rule, SSA can reopen an SSI application for any reason within any year or within 4 years for Title II, often resulting in retroactive benefits which claimants can use to pay off debts, make a down-payment on an apartment, or qualify for Title II benefits. Under the new regulations, reopening could only be requested within six months for two situations: (1) clerical error in computation of benefits or (2) clear error on the face of the evidence.

Reopening a prior application can be very important for people who clearly meet the disability standard but were unable to adequately articulate their claim in the first application, were unable to obtain evidence, or have an impairment that is difficult to diagnose. For many persons with chronic conditions, including undiagnosed mental impairments, serial applications are filed instead of appeals. Limiting the opportunity to re-open a prior application will negatively affect homeless claimants, many of whom have such conditions. We support retaining the current rules on reopening a prior application.

4. Decision Review Board

- **Concerns about selection of claims for review:** SSA doesn’t have a good track record in selecting ALJ decisions for review. For example, the Bellmon reviews in the 1980’s selected ALJs with too high a percentage of favorable decisions. How will SSA ensure that an “equal share” of favorable and unfavorable decisions will be selected? SSA said they would review decisions where errors are likely. Would cases involving co-occurring substance use disorders or disabling conditions for which an objective test is not available to demonstrate disability be over-selected for review?
- **Due process concerns:** Decisions might be made solely on the basis of a computerized profile, rather than on an individual claimant’s characteristics. Predictive screening tools would be used to select cases with a high likelihood of error. Who will select the screening criteria? Proposed procedures are complicated and would increase the bureaucratic complexity of the disability determination process.

Our broad intent is to make Federal disability programs (SSI and SSDI) more accessible to homeless claimants who are likely to qualify for benefits, and to assure that all severely impaired individuals with complex medical and social needs have access to Federal disability benefits as quickly as possible, whether or not they are experiencing homelessness.

As health care providers and advocates for displaced people, we are eager to work with SSA and with State Disability Determination Services to design and implement disability determination processes that meet the complex medical and social needs of severely impaired people who are homeless, and in so doing, to provide them with the financial and health security that is essential to their resolution of homelessness.

We will be submitting full comments on the proposed rule, developed in collaboration with other national homeless advocacy organizations, by October 25, 2005.

Evanston, Illinois 60201
October 4, 2005

Subcommittee on Human Resources
Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives

Dear Subcommittees:

I. Introduction

This is a written submission to the Subcommittee on Human Resources and Subcommittee on Social Security of the Committee on Ways and Means regarding the Commissioner of Social Security's July 27, 2005, proposed regulatory changes to the process for adjudicating disability claims under Titles II and XVI of the Social Security Act. *See* 70 Fed. Reg. 43,590–624 (July 27, 2005) (Administrative Review Process for Adjudicating Initial Disability Claims) (July 2005 NPRM). I am an attorney in private practice who represents claimants for such disability benefits.

II. The Commissioner Should Not Eliminate the Appeals Council For Claimants Dissatisfied With Unfavorable ALJ Decisions

Presently, a claimant who disagrees with an ALJ's decision has a right to seek Appeals Council review of that decision. 20 C.F.R. § 404.955 (2005). This is the last stage of administrative review before federal court. 20 C.F.R. § 422.210 (2005). The July 2005 NPRM proposes to eliminate the Appeals Council for claimants dissatisfied with ALJ decisions. This would be imprudent and inefficient.

A. Eliminating the Appeals Council Will Flood The District Courts With Meritorious Cases

Under the present system, about 100,000 claimants per year request Appeals Council review of ALJ decisions. The Appeals Council grants the requests in about 20–25% of those cases. Each year, about 15,000 claimants whose requests for Appeals Council review have been denied seek judicial review in the district courts under 42 U.S.C. § 405(g). Administrative Office of the U.S. Courts, Federal Judicial Caseload Statistics (Mar. 31, 2004). Given that Appeals Council now finds harmful error in 20,000–25,000 cases per year and corrects those errors primarily through remand to ALJs for new hearings, eliminating the Appeals Council will likely flood the district courts each year with tens of thousands more meritorious civil actions. This is imprudent and unwise. Out of a respect for the federal courts, the Commissioner should not require claimants to use the federal courts to correct tens of thousands of erroneous ALJ decisions currently corrected by the Appeals Council.

The Commissioner states that the Appeals Council presently does not “intercept[] large numbers of claims that do not withstand Federal district court review.” 70 Fed. Reg. 43,598 (July 27, 2005). Because the Appeals Council intercepts 20,000–25,000 incorrect ALJ decisions per year according to the Appeals Council, the Commissioner is mistaken when alleging that the Appeals Council does not intercept large numbers of claims that would not withstand judicial review.

The Commissioner should take great pride in her increasing ability to intercept incorrect ALJ decisions before they lead to unnecessary civil actions. Certainly, the Appeals Council does not today intercept all claims that would lead to civil actions. There are now 15,000 civil actions per year, about half of which result in judicial relief for the claimant-plaintiff. Social Security Advisory Board, Disability Decision Making: Data and Materials (Jan. 2001), at 86. Just because the Appeals Council does not intercept about 7,000 meritorious cases per year does not mean that it should cease intercepting 20,000–25,000 meritorious cases per year.

B. The Commissioner Has Tested the Elimination of the Appeals Council, But Did Not Discuss the Results

The Commissioner has already tested the effect of eliminating the Appeals Council. But in the July 2005 NPRM, the Commissioner does not discuss the statistical data from that testing. The Commissioner should make public all data from her testing of the elimination of the Appeals Council.

C. The Appeals Council is More Efficient Than the District Courts

Without the Appeals Council, the district courts will provide the appellate function previously performed by the Appeals Council. This will be grossly inefficient. Yearly, the Appeals Council handles with increasing efficiency about 100,000 requests for review. Generally, Appeals Council analysts prepare short memoranda for Appeals Council members or Administrative Appeals Officers dispose of requests for review with a minimum of effort and paperwork. Additionally, a claimant or his or her representative can present fully to the Appeals Council arguments in support of a request for review with several hours of work. In contrast, district court litigation requires at least two times and probably on average five times more resources than Appeals Council review. In district court, the plaintiff must file a complaint; the plaintiff must pay a waivable \$250 filing fee; the clerk must open a case; the Commissioner's attorney must answer; the plaintiff and the Commissioner each must file briefs of about ten to twenty-five pages stating their respective positions; and the district court may issue a written decision of about five to thirty pages. And many cases require far more resources such as when a Magistrate Judge renders a report and recommendation to which each party may object. 28 U.S.C. § 636.

If the Appeals Council is eliminated for claimants who disagree with ALJ decisions, the entire administrative process will be shorter. But from an objective perspective, the entire time spent will not be less. The time spent during efficient Appeals Council proceedings will merely be outsourced—with geometric inefficiency—to the federal courts.

D. Eliminating the Appeals Council Will Make the Entire Process More Adversarial

The Commissioner accepts that the administrative adjudicative process should be non-adversarial. But because the July 2005 NPRM substitutes non-adversarial proceedings before the Appeals Council with adversarial proceedings in federal court, the July 2005 NPRM makes the entire process—administrative and judicial—much more adversarial in aggregate. This is unwise and unnecessary.

Because the Appeals Council is today the Commissioner's highest adjudicative body and because the Appeals Council grants 20,000–25,000 requests for review each year, the Commissioner tacitly acknowledges that many ALJ decisions require readjudication. With an adversarial process in federal court, the Commissioner's attorneys would doubtless ask the district courts to affirm the denial of benefits in large numbers of these decisions that the Appeals Council today agrees should not stand. The Commissioner should not defend the incorrect denial of benefits in cases the Commissioner knows are incorrectly decided.

III. The Commissioner's Proposal is More Complex and Less Efficient Than the Existing System

The Commissioner proposes to make the administrative process for adjudicating disability claims more, not less, complex. While the July 2005 NPRM eliminates the largely formalistic reconsideration level of review, it adds another layer of attorney adjudicator—the Reviewing Official. 70 Fed. Reg. 43,595 (July 27, 2005). Under the current system, attorneys do not adjudicate claims at the initial and reconsideration level, but attorney ALJs render decisions at the third stage. The July 2005 NPRM is essentially a double-ALJ system. The Reviewing Official does everything an ALJ does except for hold a face-to-face hearing with the claimant. Instead of creating a double-ALJ system, the Commissioner should focus resources on a single attorney ALJ rendering an accurate and defensible decision in each case.

Significantly, in the July 2005 NPRM, the Commissioner has not alleged that the Reviewing Officials will make more accurate decisions than ALJs. In fact, the Commissioner envisions an ongoing process whereby ALJs explain to Reviewing Officials why their decisions were incorrect. Instead of hiring hundreds or perhaps even thousands of Reviewing Officials to literally duplicate the functions of ALJs (except for the holding of face-to-face hearings), the Commissioner should devote the scarce resources of the Social Security Administration to improving ALJ adjudications after the initial denial of benefits.

IV. The Commissioner's Proposed Closing of the Record Includes Unworkable Time Limits

The Commissioner proposes to close the record, imposing strict time limits on the submission of evidence to an ALJ. 70 Fed. Reg. 43,596–597 (July 27, 2005). In the Commissioner's view, a claimant can "easily" submit evidence to an ALJ twenty days before a hearing when the claimant is given a forty-five-day notice via mail about the upcoming hearing. 70 Fed. Reg. 43,597 (July 27, 2005). There is no empirical support for this assertion. Assuming that a claimant receives a notice three days after it is mailed and assuming that the claimant can instantaneously submit evidence to an ALJ, a claimant essentially would have three weeks to obtain updated medical records from all hospitals, clinics, doctors, etc. A large number of medical sources, including hospitals, clinics, and doctors, take far more than three weeks to respond fully to a request for medical records.

V. Summary

The Commissioner's proposed process has significant flaws warranting major revision and thorough testing. The Commissioner should rethink her plan and focus on improving the current system instead of implementing a double-ALJ system without Appeals Council review for claimants who disagree with ALJ decisions.

Very truly yours,

Eric Schnauffer

Statement of James Shaw, National Association of Disability Representatives, Belleville, Illinois

The National Association of Disability Representatives (NADR) welcomes the opportunity to provide our perspective on the proposals for reform of the Disability Determination Process. We commend both the House Subcommittees and SSA for reaching out to hear from interested parties during the public comment period on the Commissioner's proposals, and we hope that our insights will prove valuable to SSA as it drafts a final rule.

By way of background, NADR represents more than 200 professional disability representatives, attorneys and non-attorneys alike. Our members, who work and practice in all areas of the country, have both small and large practices, and bring a wide variety of unique expertise, including training in vocational rehabilitation, mental health, medical management including nursing, and the Social Security disability review process. We have worked with DDS staff at the local level, and with SSA staff on broader issues, including the current demonstration project providing fee withholding for non-attorney representatives. It is with this broad experience and knowledge in mind that we submit our comments regarding the proposed disability claims process.

Positive Changes in the Commissioner's Proposals

NADR believes there are many proposals within the proposed rule that contain significant merit, and would like to outline four which we consider particularly valuable. First, we are encouraged by the Commissioner's proposed "Quick Disability Determination" structure, which would allow clearly disabled individuals to receive a decision regarding their benefits within 20 days of applying. NADR believes this concept will have two beneficial effects. First, a rapid determination decision on the most critical cases would allow those individuals and their families to receive help swiftly and efficiently. Second, a quick disposition of "clear-cut" disability cases will allow state and SSA officials to focus their time and resources on more complex and nuanced cases, which may have additional medical and other questions that need answers.

Second, we believe that SSA's continued movement toward the use of electronic folders will certainly increase efficiency for claimants, shortening the time needed to process and adjudicate claims. A secure, "paperless" system provides for easier access to claims documents, as recent events in the Gulf Coast have demonstrated the logistical nightmares that can result when paper-based medical and claims records are damaged or destroyed. With the Veterans Administration having adopted a system of electronic medical records, and private practices beginning to follow suit, we also hope that SSA's system will be designed to be interoperable with electronic medical records systems in the private and public sectors, further improving the system's efficiency and ensuring that no piece of relevant evidence will get "lost in the cracks."

Third, the proposed National Network of Experts has the potential to provide a much more uniform approach to the analysis of disability cases. The experiences NADR members have had with medical and vocational experts strongly suggest that this process improvement will enhance the decisionmaker's understanding of medical conditions by utilizing experts who are familiar with those disease processes. Presently there appears to be a dearth of specialists who will consult or testify at hearings and, consequently, alternative professionals who may not be as familiar with the signs and symptoms of diseases outside their specialties are forced to testify.

We also agree with the Commissioner's proposal to allow for a separate review from a National Network Expert should the case reach the ALJ level. This approach will preserve consistency, but will also allow for a second, fresh opinion of the facts of the case.

Fourth, the pre-hearing order proposal will bring additional clarity and efficiency to the claims adjudication process. Several NADR members utilize this process currently, and report that such a step can reduce claims processing times by as much as 6 months. Allowing the judge to go right to the heart of the case through a pre-hearing order is entirely in line with the Commissioner's intent to streamline the claims process, and we strongly support this concept.

Concerns With the Commissioner's Proposals

However, NADR members find several areas of concern with the Commissioner's proposed rule.

SSA Claimant Deadlines

The Commissioner proposes a number of new deadlines for claimants as they navigate the review process, including a prohibition against submitting any new evidence later than 20 days prior to the hearing and no new evidence more than 10 days after the hearing.

These proposed limitations against evidence present several problems. First, many claimants wait to get representation until they reach the ALJ level. This means that a representative may have severe time constraints in getting medical records from institutions that do not feel or are not equipped to render a speedy response. At the other extreme, representatives that obtain medical records too early in the process will probably be told that the evidence is "dated" and will have to update the medical information. This places an additional burden on the already strained and expensive healthcare system.

Second, approximately 20% of claimants lack representation when appearing before an ALJ, and may have significant difficulty navigating and adhering to the proposed deadlines.

Flexibility is needed for the submission of evidence to allow for these circumstances. Without such flexibility, documents vital to a claimant's case could be ruled inadmissible, harming the claimants ability to get a fair and complete hearing. If the Commissioner has a concern that representatives are utilizing various forms of delay tactics to prolong cases (thereby enhancing their compensation), we would propose that the Commissioner use her existing powers to sanction representatives who abuse the process.

Some deadlines are needed in order to shorten the Disability Determination process. However, those targeted at claimants miss the mark, because most of the delays in the review process occur on Social Security's end. Claimants have a powerful incentive to move through the review process quickly because of their need for income and assistance; however, no such incentives exist for SSA. In fact, NADR representatives report, via their own experience, that SSA can vary anywhere from as little as one month to more than 15 months in holding an oral hearing, with OHA's delays varying broadly by geographic region. In addition, once the ALJ hearing has taken place, judges have taken as little as two weeks or as much as one and one-half years to issue a decision after the hearing.

SSA's proposals set only one "goal" (not deadline) for themselves: ALJ hearings should be scheduled (but not occur) within 90 days of the application. No punitive action is taken if said goal is not met. The proposal lacks a deadline or "goal" for how quickly a hearing should occur, or how swiftly a decision should be rendered once the hearing has taken place.

In our opinion, SSA should revoke the deadlines placed on claimants and, instead, create deadlines for themselves on both hearings and decisions. Toward that end, NADR would recommend that SSA be required to set the month of the hearing date within 60 days of receiving a request for review. Second, the hearing should occur within 180 days of the hearing request being filed. And third, a decision should be rendered within 30 days of the hearing.

Submission of Favorable and Unfavorable Evidence

We understand the need for SSA to see both sides of a case in order to make the most informed decision. However, the proposed rule requiring a claimant or his/her representative to submit both favorable and unfavorable evidence to the ALJ may present ethical difficulties for attorney representatives, who may be compelled to present facts contrary to their clients' interests. We would also note that current language already exists prohibiting representatives from withholding evidence; the Commissioner's proposal would exceed that standard, and may require representatives to essentially compile two cases for every claimant—one case proving eligibility, another case disproving eligibility. Given the logistical and ethical difficulties associated with this proposal, we would hope that SSA would instead make additional personnel available to investigate cases and develop any unfavorable evidence and arguments with respect to disability claims.

Lastly, NADR believes that eliminating a claimant's ability to appeal from the ALJ decision to the Decision Review Board places an unrealistic burden on the Board to know when a bad decision has been made. The sheer volume of ALJ cases alone would likely preclude any attempt by the Board to conduct the thorough reviews needed to ascertain whether a particular ALJ decision merits further scrutiny. We would therefore propose that a claimant be permitted to appeal to the Decision Review Board.

Again, NADR thanks the Subcommittees for calling a hearing on this important subject. We would be happy to provide your staff or SSA any additional technical details you may require in reviewing the Commissioner's proposals.

Statement of Jason Turner, Heritage Foundation, New York City, New York

SEVEN POINT TESTIMONY

1. The increase in the SSI population among those of working age should be cause for alarm. The growth in SSI applications of more than 30% is due in part to institutional incentives to increase the numbers qualified as disabled. For every welfare recipient who moves from TANF to SSI (or SSDI), states save TANF block grant funds which are substituted by 100% federal disability funds. Almost all states have financed SSI advocacy within their welfare system to facilitate this transfer.

2. The number of working-age adults who are receiving SSI disability payments as a proportion of the population has increased threefold since 1970. And yet there is no evidence that our population as a whole is getting sicker.

3. Recipients of SSI almost never return to work. Nor does the current system incorporate any obligations that recipients take constructive vocational steps toward rehabilitation, where feasible. In this sense, SSI is comparable to the old AFDC program, and it is having the same debilitating long-term effects on those it is assisting. *SSI is becoming the long term welfare successor to the AFDC program.*

4. Many of the lessons learned from national reform of the welfare system can be applied to disability reform. There is a substantial overlap in the population of SSI applicants and current welfare recipients. (One third of non-elderly women and children who began receiving SSI benefits were at the time of application receiving TANF).

The U.S. Congress, through its proposed TANF reauthorization legislation, has appropriately asked states to engage larger proportions of recipients in constructive work-related activities, sometimes termed "universal engagement." As a result, states are increasingly looking for additional ways to engage the mildly disabled in work related activities, and the SSI system should do the same.

5. The following lessons from welfare reform can be applied, with certain modifications, to disability reform:

- Maximizing self-reliance should be the program goal.
- The longer a recipient remains inactive within the system, the more difficult it is to significantly alter life circumstances.
- Not everybody can become fully self-sufficient, but all should contribute to the best of their abilities consistent with their capabilities.
- Required constructive work and vocational activities are the only way to yield substantial results. Voluntary program options are not effective and rarely taken advantage of by recipients.
- Tight connections between attendance in program activities and cash benefits result in participants taking their obligations seriously.
- Regular reviews of self-sufficiency progress assure that recipients are not languishing.

- Appeals by recipients should be handled forthrightly and expeditiously, and the role of administrative law judges in overturning decisions made by the welfare agency should be sharply circumscribed.
6. Welfare reform lessons which can apply to disability reform, including the following:
- The notion that disability eligibility is a “zero-one” determination is outmoded. Partial work is increasingly feasible for a majority of disability cases. Improvements in medical technology and employer obligations to reasonable accommodation should result in higher, not lower, participation of the disabled in the workforce. *Functional assessments* which show what disability applicants and recipients *can do* should replace the all-or-nothing determinations of an *inability to work*.
 - Even those currently unable to work in the private economy should make continuous efforts to improve their circumstances through vocational rehabilitation, except in unusual circumstances.
 - Participation in ongoing constructive activity while receiving benefits, known as “activation,” is the best way to assure that those currently unable to work will be able to re-engage in the labor force if and when their underlying medical condition improves.
 - As part of the law creating Ticket to Work, the Congress withdrew the right of the Social Security Administration to *obligate* participation in vocational rehabilitation as a condition of receiving disability benefits. This agency right should be restored.
 - Regular and complete de novo periodic medical reviews of current recipients should be required. At a minimum, a subset of profiled cases which are most likely to show improvement should be reviewed.
7. Recommendations to improve the Proposed Regulations for a New Disability Determination Process:
- Commissioner Barnhart has shown remarkable insight into the often impenetrable area of administrative processing. Taken together these changes constitute a significant improvement over the status quo.
 - However, these regulations do not substantially alter the excessive role and latitude enjoyed by the Administrative Law Judges (ALJs).

The current system takes the careful medical and vocational review made by state disability determination bureaus and upon appeal places it in the hands of lawyers largely without medical credentials (ALJ's) for a de novo review.

There is no good reason to provide for a de novo review by non-specialists. Any appeal should take into consideration all the evidence presented in making the original decision (the NPRM requires reference to the previous determination but does not require its use in the ALJ decision itself).

There is wide variation in the reversal rates of individual ALJ's. Even more importantly, the high overall ALJ reversal rate means that many individuals obtaining eligibility for SSI are likely to be only mildly limited, and could have led a more satisfying, productive life engaged in vocational rehabilitation leading to part-time or full-time employment rather than full disability.

The establishment of a Decision Review Board made as part of these proposed rules will not significantly alter the dynamic described above. Congressional action may be required.

- The back-to-work demonstrations contemplated by SSA are constructive but they leave the decision to participate in the hands of disability applicants and recipients.

Experience from welfare shows that despite experiments which created substantial financial incentives to go to work, most welfare recipients did not respond until they were required to do so as a result of the TANF reforms. This sheds light on why there is such a low utilization rate of the voluntary Ticket to Work program.

SSA should experiment with back-to-work efforts which are obligatory, not just voluntary. These are far more likely to yield results.

And new experiments should be initiated which alter the existing financial incentives for states to push the maximum number of welfare recipients into permanent disability status.

**Joint Statement of Unaffiliated Colorado Disability Attorneys, Fort Collins,
Colorado**

IF YOU DON'T HAVE TIME TO DO IT RIGHT, YOU MUST HAVE TIME TO DO
IT OVER.—ANONYMOUS

I. INTRODUCTION

As attorneys representing claimants before the Social Security Administration, we disagree with numerous facets of the proposed changes to the regulations. These are discussed below. They can be summarized, however, by the above saying—"If you do not have time to do it right, you must have time to do it over." The proposed changes emphasize expediency at the expense of thoroughness. They may result in the administration more quickly denying claimants, however they also remove aspects of the system that encourage the accuracy of decisionmaking. As a result of the proposed changes, wrongly denied claimants will appeal and reapply. Hence, any potential for increased efficiency will be lost to repetition.

These comments will proceed through the current disability process, pointing out its flaws and commenting on the proposed regulations as they become relevant. In this way, we hope to make it understandable to readers not familiar with the current process.

II. THE APPLICATION

Currently, claimants apply for disability through their local offices, the Internet, or an 800 number. We agree with the proposed changes, which improve Internet access and electronic filing.

III. THE STATE DISABILITY DETERMINATION SERVICES

After the application is processed, the case is sent to the state Disability Determination Services (DDS), where it is developed.

To develop the file, DDS will order records from the medical providers listed on the claimant's application. DDS will also send out interrogatories to the claimant. Most common among these are the work history report, daily activities questionnaire, and personal pain questionnaire. The claimant is to answer the questions on these forms and return them to DDS. These forms have the potential of telling the Administration everything that they need to know about the case. They are often, however, filled out less than perfectly by unrepresented and sometimes less educated claimants. Hence, the information on these forms is only as good as the writing skills, thoroughness and candor of the authors. DDS will also occasionally send forms to the family and friends of the claimant.

DDS will then consult with their own medical and vocational experts. On occasion, they will send claimants to consultive examinations. From the attorney perspective, the reports of consultive examiners are rarely useful. The consultive examiner meets briefly with the claimant and appears to have limited background information. The consultive examiner then dictates a boilerplate report that can result in errors. For example, one attorney had a claimant swear that the physician had leaned over and personally helped him put on his shoes and socks however, the physician's report stated that the claimant had no difficulties putting on his shoes and socks.

We believe the process of the consultive examination could be improved, and support efforts to do so. The proposed national pool of experts has the potential of improving the quality of consultive examinations, however, it can just as easily make no significant difference. The consultive exam process would be best improved through examiners spending more time reviewing the records, interviewing the claimant, and checking reports for accuracy.

IV. RECONSIDERATION

After the first DDS denial, the claimant requests Reconsideration. The Reconsideration decision is made by the same state DDS that initially denied the claim. For this reason, it contributes little to the process. For some years, Colorado has been one of ten prototype states, skipping the Reconsideration step. As Colorado attorneys, we feel this experiment has streamlined the disability process and hence support the permanent removal of Reconsideration from the disability claims process.

V. THE PROPOSED "FEDERAL REVIEWING OFFICIAL"

After denial by DDS, the proposed regulations purport to create a body of Federal Reviewing Officials (FROs) who will further develop the file and make another decision on the claim. This proposal would institute an entirely new step or level in the disability claims process. We think this additional step has the potential of creating

a bottleneck in the system without adding any significant benefits to the medical-vocational evaluation.

Apparently, some 1,500–3,000 attorneys or other legally trained officials would be hired nationally as FROs. If this program is instituted, we predict that as claims increase and cases pile-up, there will be enormous pressure on the FROs to make decisions quickly. The individual FROs' performances will likely be judged in part by the number of cases they are able to push through the system. Hence, evidentiary development will be discouraged and quick denials will be encouraged. The end result will be that most FRO decisions are meaningless rubberstamps of the original DDS denial.

Further, it is simply a fact that most Social Security disability claims ultimately turn on subjective complaints and issues of credibility. Hence, any official who does not have true fact-finding powers will not be able to resolve the ultimate issues in the case. As a result, almost every case will go to hearing anyway.

Finally, this sort of thing has been done before. In the 1990s, Colorado participated in an experimental level in the process known as the Adjudicating Officer (AO). http://www.ssa.gov/OP_Home/cfr20/404/404-0943.htm. It was part of the New Government programs instituted during the Clinton administration. <http://www.hhs.gov/news/press/pre1995pres/940907a.txt>. Those attorneys who experienced the program observed that it began strongly with the Adjudicating Officers actually conducting mini-hearings. However, as time went on, the role of the AO became nothing more than a person making a phone call to see if there was any new evidence. Overall, the disability attorneys felt that the AOs did not fully understand the law and avoided most determinations of fact. Further, after reviewing the record and perhaps meeting with the claimant, the AOs prepared summary decisions. Some attorneys felt so strongly that these summaries were misleading and inaccurate, they refused to sign them and prepared their own statements. We feel that the proposed Federal Reviewing Official is similar to the failed Adjudicating Officer and would not succeed for similar reasons.

In conclusion, rather than creating an entirely new step or level in the disability claims process, we feel that administrative and financial efficiency would be better served by increasing the number of staff attorneys and Administrative Law Judges at the existing Office of Hearings and Appeals. Currently, the Denver OHA employs only three staff attorneys for review of claims. We think this number should be greatly increased. Some of these additional OHA staff attorneys might even be assigned to specific judges, giving busy ALJs opportunities to delegate appropriate tasks.

The best place for the resolution of legal and factual issues is at a hearing, in front of a judge. Adding yet another step in the disability claims process will not change this simple fact.

VI. WAITING FOR THE HEARING

When a hearing is requested, the file is transferred to the regional Office of Hearings and Appeals. Within about six weeks, a letter is sent to the claimant explaining that the file is received and the claimant will be notified at least 20 days before a hearing date. Many claimants interpret this letter to mean that they will go to hearing very soon. Actually, the Denver Office of Hearings and Appeals is running about 14 months from request to hearing.

During this long wait, many claimants suffer extreme financial and emotional hardships. The lucky ones have savings accounts, working spouses, health insurance . . . etc. Many do not. Some claimants are able to continue their health insurance into the period of their disability by paying expensive COBRA premiums. Others cannot afford this or never had health insurance at all. Many claimants come to Social Security after losing coverage in the Colorado worker's compensation system.

As representatives, we are familiar with the charitable resources available in our communities. We regularly refer clients to community medical clinics, community mental health clinics, Colorado Indigent Care Program, Aid to Needy and Disabled, food stamps, county housing authorities, Low Income Energy Assistance Program, privately run soup kitchens and shelters . . . etc. A poor system affects the entire community.

We representatives are often asked by our frustrated clients, "how can this happen?" They say, "I paid my taxes, I worked hard in my life. Didn't I do that, so that I could have help now, when I need it?" We have no answers for them. We can only say that there is currently a gap in the social safety net that no one seems to acknowledge, until they fall into it themselves.

Due to finances, during the wait for hearing many claimants neglect medical care. This failure to seek medical care can be fatal to their disability case, as it creates

a gap in medical evidence that can be perceived by an Administrative Law Judge as a lack of credibility.

The lack of medical care also creates a situation where the claimant no longer has a treating physician with whom they have history and rapport. Many claimants must go to busy community medical clinics. The lucky ones are able to see the same doctor on several occasions. The unlucky ones see various professionals, so that no single professional is available to attest to the claimant's functional capabilities. Since, the actual evaluation of disability, relies heavily on the opinion of a treating physician, not having a treating physician is detrimental to accurate evaluation of the case.

In general, lack of medical treatment is a difficult problem that cannot be solved by a few regulation changes. Administrative Law Judges cannot make accurate disability decisions without quality medical opinions upon which to base them.

VII. EVIDENCE AND THE HEARING—THE PROPOSED “GOOD CAUSE” STANDARD

More than a year after filing the Request for Hearing, the hearing is finally scheduled. Currently, the representative gets about 30 days notice prior to this hearing. After more than a year of waiting, medical records need to be updated. Under the Health Insurance Portability and Accountability Act (HIPAA), providers have 30 days to provide these records. If mailing time is tacked on either side, it may take as much as 40 days to update medical records for a hearing that is less than 30 days away.

It is difficult to update medical records in advance for several reasons. First, it costs dollars every time the record is updated because the providers charge for the copies. Second, the claimant/representative does not know when the hearing will be scheduled. It may be scheduled in month 12, however it may also be scheduled in month 15. It is in the interest of accuracy to have the most updated records. A great deal of relevant information can be produced in a single medical visit.

The too often result of the short notice of hearing, is that the ALJ receives medical evidence less than a week before the hearing, sometimes immediately before the hearing. ALJs find this understandably frustrating. We feel that more advanced notice of hearings would do much to cure this problem.

However, the proposed regulations ineffectively attempt to cure this problem by simply making a rule. The proposed rule is that barring “good cause,” no medical records will be accepted after 20 days prior to hearing. The proposed changes *do* provide that the hearing will be scheduled 45 days in advance, however, 45 days is not sufficient time. A hearing that is scheduled 45 days prior leaves the representative only 25 days to update the record. As explained above, under the requirements of HIPAA it may take at least 40 days to update the record—and that is only if the providers are compliant. As representatives, we often have to follow-up with delinquent medical providers.

Hence, we feel that if the proposed 20-day rule is instituted, the hearing should be scheduled at least 60 days in advance. In the last year, one ALJ at the Denver Office of Hearings and Appeals has scheduled hearings many months in advance. Most of us have found this experiment extremely positive. Instituting early scheduling would allow the representative, the claimant, and the medical care providers to be more prepared for the hearing, thereby relieving pressure on the ALJs and avoiding continuances.

The proposed regulations do provide that the hearing should be scheduled within 90 days of the Request for Hearing. If this early scheduling actually occurred, it would go a long way to solve the above discussed issues.

Still, regardless of how early the hearing is scheduled, as disability attorneys, we generally oppose the proposed 20-day rule. We oppose it because we know from experience that despite all best efforts and intentions, there will still be medical evidence obtained late. No matter what precautions are taken, and what rules or guidelines are instituted, it will still happen. This might be due to busy doctors procrastinating interrogatory questionnaires, claimants who do not do what they have been asked to do until the hearing is imminent, uncooperative medical facilities, evidence not learned about until later, and even mistakes or oversights on the part of representatives.

The proposed regulations purport to deal with these inevitable late submissions through a “good cause” standard. Under the proposed regulations, determining “good cause” would be left entirely to the discretion of the Administrative Law Judge. The proposed regulations do not specifically provide for a review of this determination. If this rule is instituted, we feel that at the very least, there should be a review of the ALJ's decision. This might be done in much the same way the proposed regulations provide for a review of dismissals. ALJs are only human and

susceptible to making wrong decisions and/or decisions based on factors other than “good cause.” A decision whether to allow relevant evidence has the potential of affecting the claimant and his family for years to come. There should be recourse to an appellate body.

As relevant evidence is denied for good reasons or bad ones, the inevitable result will be representatives continuously taking the issue of “good cause” to the Federal District Courts. Eventually, one or two District Courts might develop a standard of reviewing this determination, and a whole new body of law could spring up around it. All of this potential litigation is in the name of expediency. All of this potential litigation is to avoid requiring ALJs to read medical evidence before a hearing.

Appealing and/or denied claimants will also reapply, further congesting the system. It would be very unfortunate if many of these new applications and appeals could have been avoided by allowing a few pages of evidence, just prior to the hearing. As disability attorneys, we believe that efficiency is best served by doing everything possible to decide cases accurately the first time. Excluding relevant evidence—even for the best of reasons—would erode this purpose.

Finally, the “good cause” standard will take up valuable hearing time. Hearings are usually scheduled 45–90 minutes apart. We have seen them scheduled as little as 30 minutes apart. The time for the claimant to present his or her case is already limited. We believe the proposed “good cause” standard will result in taking up 10–15 minutes in many disability hearings, to discuss whether to allow relevant evidence. This scenario is unfair to claimants who have waited more than a year for their day in court.

VIII. REOPENING

Currently, a claimant who has applied for disability multiple times can request that prior DDS and ALJ decisions be reopened in a subsequent claim. Whether to reopen a prior ALJ’s decision is within the discretion of the new ALJ. Although reopenings are often requested, they are not frequently granted. The proposed regulations purport to eliminate this provision. We disagree.

Elimination of this provision would most strongly affect the uneducated, mentally impaired and/or unrepresented claimants. For example, a mentally impaired individual with an elementary education might apply for disability several times before he realizes that he should request a hearing and obtain representation. In the meantime, his insured status for Social Security Disability Insurance (SSDI) benefits has run out. The current regulations allow an ALJ to correct this unfortunate event by reopening one or more prior filings. Removing the reopening provisions would eliminate this option to the ALJ. As a result, the above hypothetical individual and others like him would permanently lose their SSDI benefits.¹

IX. THE APPEALS COUNCIL AND THE PROPOSED DECISION REVIEW BOARD

Currently, Claimants who are denied at the hearing level ask an administrative agency known as the Appeals Council to review their cases. The Appeals Council looks at the record, the ALJ decision, and any post-hearing evidence submitted. If the Appeals Council does not “review” the case, the ALJ decision becomes the final agency decision. If the Appeals Council reviews the case, the body can affirm, overturn or remand an ALJ decision. If the Appeals Council remands an ALJ decision, it is usually accompanied by specific instructions to the ALJ. It is only after the Appeals Council decision that a Claimant can appeal to Federal District Court.

Currently, it takes an average of 8–12 months for the Appeals Council to process a case. This amount of time can be increased by a variety of factors including requests for the copies of the record. Due to this length of time many representatives advise disabled claimants to reapply for benefits. Hence, the claimant will now have two cases—one at the Appeals Council and another moving through the application process a second time. The principle of *res judicata* applies to the agency’s final decision on the first case, with the exception of the previously discussed reopening provisions. If the Appeals Council remands the case to the ALJ, the two cases will ultimately be consolidated at the Office of Hearings and Appeals.

The proposed rules purport to eliminate the Appeals Council and replace it with a Decision Review Board. This body would review the decisions of ALJs on its own motion rather than the claimant’s. Cases would be chosen for review based on a variety of statistical factors. As such, the proposed Decision Review Board is not so much an appellate body as a quality control committee. It conducts a statistical type review of the ALJ decisions in order to provide data and feedback to the Administra-

¹ If the claimant has few financial assets and does not live with relatives who do, he might still be eligible for Supplemental Security Income (SSI).

tion. We think such a committee is a good idea and might be incorporated into the existing Appeals Council. However, it is not a true appellate body that in any way replaces the existing Appeals Council.

Although the Appeals Council is backlogged it serves the purpose of giving the claimant and the Administration one last chance to correct legal and factual errors. This last look can avoid needless filings in Federal District Court. Problems solved by the Appeals Council can be as simple as misunderstandings between the claimant and the ALJ. For example, an ALJ once cited a claimant's hunting trip as being one reason the claimant was not disabled. The hunting trip, however, had actually turned into a situation requiring emergency personnel due to the claimant's impairments. This material misunderstanding was caught at the Appeals Council level. The claimant was ultimately approved for disability benefits without enlisting the time and energy of the Federal District Court. The proposed Decision Review Board could not serve this purpose, because the review would not be claimant initiated but internally initiated.

The existing Appeals Council also serves the purpose of checking the power of the ALJ. Like anything else in life, the opinions and life experiences of ALJs differ. Some are more conservative, others more liberal. This can affect the way that a claimant is treated in a hearing. The Appeals Council provides an opportunity for the agency to correct these potential problems internally.

Finally, the proposed regulations purport to close the record after the ALJ decision.² We disagree. As discussed in § VII above, we are of the opinion, that so long as there is evidence relevant to the claimant's work capabilities, and the decision is still pending, the Administration should accept and examine that evidence. Allowing relevant evidence now rather than later prevents needless repetition. For example, a claimant may have an unexplained cluster of symptoms, which results in a hearing denial. However, after the hearing denial, a neurologist diagnoses her with Multiple Sclerosis using objective medical criteria. If the record were closed at the ALJ decision, the claimant would not have the opportunity to present this evidence to the reviewing bodies. She would have no choice but to start another application. When this proposed closing of the record is combined with elimination of the reopening provisions, a very unjust scenario results—a claimant who was legitimately disabled has to reapply and is ultimately denied years of benefits. This injustice was done in order to avoid forcing the reviewing officer to read a few pages of medical evidence.

In general, we are of the opinion that all these costly, and likely ineffective, changes to the fundamental structure of the system can be avoided, by hiring more judges and clerks. Speeding up the Appeals Council should be as simple as providing the staff necessary to review the large number of files presented to it. Removing a true appellate body from the Administration will result only in many of these same cases being filed in Federal District Court.

X. CONCLUSION

In summary, many of the proposed changes to the regulations simply miss the boat. They do not actually address the inefficiencies of the process, and the real problems of the system. Instead they seem an effort to deny as many claimants as possible as quickly as possible. The inevitable long-term result of this will be repetitive applications and appeals of denied claimants. This repetition will not increase efficiency, but further congest the system.

We think that administrative and financial efficiency of the Social Security disability system can be best served by the following principles:

1. Improve technology through use of the Internet, electronic filing of paperwork, and electronic files.
2. Improve the quality of health information available to the ALJ. (This issue is impacted by the health care system at large.)
3. Get the claimant in front of the ALJ as quickly as possible, as the ALJ is the official who has the authority to make necessary determinations of credibility, fact and law.

²Proposed § 405.373(a) provides that the ALJ can consider new evidence provided within 10 days of claimant's receipt of the denial, if there is "an unforeseen and material change" in the claimant's condition, or the ALJ had held the record open for a prescribed period of time, and claimant has good cause for missing that deadline. If the Decision Review Board elects to review the case, § 405.373(b) provides that the board can consider new evidence if the showings required in paragraph (a) are made. In other words, evidence after the decision is allowed only in very limited circumstances.

4. Maintain an appellate body within the Social Security Administration, so that legal and factual errors in hearing decisions can be assessed prior to U.S. District Court filings.

5. More fully staff and fund the *existing* steps of the disability claims process to better handle the claims of the aging population.

Finally, there are many individuals with significant health restrictions who are willing but unable to find work. Some of these individuals may not meet the strict Social Security definition of disabled, however they are forced to apply for benefits regardless. Their applications are made necessary because many employers will not hire individuals with prior work injuries and/or restrictions. Employers apparently take this action, because they are concerned that the individual will again become injured. Some disability applications might be avoided by better encouraging employers to hire individuals with prior injuries and restrictions. Tax incentives in this area might make up for the perceived financial risk to employers and do much to delay the upcoming burden on the Social Security program.

As disability attorneys, we will be happy to answer any questions or concerns regarding these comments or the disability process in general.

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